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ABSTRACT

Multiple sources were used to study the status of children in the District of Columbia, and recommendations for the improvement of their living conditions and opportunities are made based on these findings. The health and well-being of children in the U.S. capital lag behind the rest of the nation. One in 3 children in the District of Columbia lives in poverty, a rate 40% higher than the national average. The mortality rate for black infants places the District last among states and last among the nation's largest cities with measurable black infant death rates. More than 25 children a day are reported abused or neglected, and more than 5,000 juveniles were arrested in 1990. Every night, 1,300 children sleep in shelters across the city. Conditions have been worsening, and District officials have failed to use all available federal assistance to meet the needs of children and families. Recommendations for improvement of children's status are made in the areas of: (1) maternal and child health; (2) housing and homelessness; (3) the child welfare, mental health, and juvenile justice systems that can help vulnerable children; (4) family income; and (5) city management and budget practices. Suggestions are made for community action to help children, including the establishment of tutoring and mentoring programs. Civic and social, religious, and business organizations can all help, and all citizens must feel an obligation to place children higher on the political agenda. Appendices present information about District officials, volunteer opportunities, organizations that can help the District's children, and a list of 15 selected resources. (SLD)

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# Bright Futures or Broken Dreams

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## The Status of the Children of the District of Columbia and an Investment Agenda for the 1990s

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## Children's Defense Fund

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# About CDF

The Children's Defense Fund (CDF) exists to provide a strong and effective voice for the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of poor, minority, and disabled children. Our goal is to educate the nation about the needs of children and encourage preventive investment in children before they get sick, drop out of school, suffer family breakdown, or get into trouble.

CDF is a unique organization. CDF focuses on programs and policies that affect large numbers of children, rather than on helping families on a case-by-case basis. Our staff includes specialists in health, education, child welfare, mental health, child development, adolescent pregnancy prevention, and youth employment. CDF gathers data and disseminates information on key issues affecting children. We monitor the development and implementation of federal and state policies. We provide information, technical assistance, and support to a network of state and local child advocates. We pursue an annual legislative agenda in the U.S. Congress and litigate selected cases of major importance. CDF's major initiatives include our adolescent pregnancy prevention program and a prenatal care and child health campaign. CDF educates tens of thousands of citizens annually about children's needs and responsible policy options for meeting those needs.

CDF is a national organization with roots in communities across America. Although our main office is in Washington, D.C., we reach out to towns and cities across the country to monitor the effects of changes in national and state policies and to help people and organizations concerned with what happens to children. CDF maintains state offices in Minnesota, Ohio, and Texas. CDF has developed cooperative projects with groups in many states.

CDF is a private nonprofit organization supported by foundations, corporate grants, and individual donations.

## CDF's D.C. Project

The CDF-DC Project Office formally opens with the release of this report. The office was created to add another strong voice for children in the District of Columbia. The staff will work diligently to ensure that children and families become a top community-wide priority. Phyllis B. Wolfe is the Project Director; she will be assisted ably by her associate, Olati Johnson, and supported by Delores Dawson, as the Administrative Assistant.

# Bright Futures
# or
# Broken Dreams

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## The Status of the Children of the District of Columbia and an Investment Agenda for the 1990s

Children's Defense Fund

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Children's Defense Fund
122 C Street, N.W.
Washington, DC 20001
(202) 628-8787

## Dedication

This report is dedicated to the memory and legacy
of Reverend Henry C. Gregory III,
Minister of Shiloh Baptist Church from 1973 to 1990.
Shiloh's Family Life Center is a beacon for all
religious congregations to focus their ministries,
leadership, and stewardship on strengthening children
and families.

It also is dedicated to the memory
of the 117 children and youths
who died in our city during 1990
from the violence of poverty, drugs, and guns.
May their senseless and preventable tragedies
move us to save other children and youths
from similar fates.

# Acknowledgments

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CDF owes special thanks to staff of both public and private child-serving agencies and to other child advocates throughout the city who shared their comments and perspectives on children in the District, and to those who allowed us to visit their wonderful programs. We are grateful for the studies, reports, data, and anecdotes that helped us compile this report.

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Several CDF staff persons worked tirelessly on this report:

- MaryLee Allen, Nancy Ebb, Olati Johnson, Joe Liu, Lisa Mihaly, and Phyllis Wolfe are particularly noteworthy, for they were the principal authors -- giving the report form and substance.
- David Heffernan, Donna M. Jablonski, Janis Johnston, and Stephen Wilhite did the editing and production.
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## Foreword

This is a hopeful report -- not a jeremiad of despair. It is about what we can do together to push our city from the bottom to the top of national performance on key child indicators. It is about a new beginning with a new city administration that needs our citizen support -- and demand -- to place child investment at the top of our community's agenda.

This report also is a challenge to the President of the United States and to the Congress to exercise the same level of leadership and apply the same sense of urgency to rescuing the 40,000 poor children living in the capital of the Free World -- as well as the more than 12 million poor children all across America -- from the tyranny of poverty and drugs and violence as they did to rescuing the children of Kuwait from Saddam Hussein's tyranny.

This report is a call to caring and to action by every citizen -- public and private -- to make the American Dream live for every child in our midst.

It may be understandable and forgivable that thousands of children die in Third World countries every year because their nations cannot afford to meet their needs. I find it neither understandable nor forgivable that thousands of children die in our great nation and city when we have the capacity but not the will to save them. The great theologian Walter Rauschenbusch reminded us several decades ago that "it is possible to kill a child just as surely with a tenement as with a stiletto." Today more children are dying from the effects of preventable poverty and its progeny -- hunger, homelessness, and hopelessness -- than from muscular dystrophy, diabetes, cystic fibrosis, and cancer combined. Child poverty is curable and preventable in rich America. And you and I are the healers who, with our voices, our time, our votes, and our resources must move our city and nation to live up to its ideals and take the needed steps to preserve our collective future.

CDF wants to do its part in this crusade to save all our children alongside the many wonderful advocates and providers already working on behalf of children in our city. Our new local District of Columbia office and all of CDF are committed to working with the mayor, city council, Congress, White House, the business community, and black and Latino and white community leaders to lift the barriers that harm too many of our children.

We seek to reinforce and support and to not duplicate. We seek to be constructive and helpful and not just critical. But we will insist that children be given a place at the budget and political decision-making table so that their needs can be heard and met. We seek to close the gap between have and have-not children in our city and help contribute to a better overall sense of community. How can it be acceptable that a child living in Ward 8 is two-and-one-half times as likely to die before his or her first birthday as a child living in Ward 3; that a child in Ward 1 is 15 times as likely to be poor as one in Ward 3? How can we tolerate a First and Third World struggling to co-exist within our city -- two sets of expectations and opportunities for children who chose neither their parents nor neighborhood?

How can we continue to tolerate violence in our city that literally imprisons many District children in their homes? What have we come to as a city and as a nation when a parent is quoted in the September 2, 1991, *Washington Post*, saying: "My 11-year-old son asked me if he could go watch [the band] last night.... I wouldn't let him because I'm afraid for my son's life."? With justification. The story's headline was: "Teen slain, 3 wounded at concert in Congress Heights schoolyard."

This is not my vision of what America or the District stands for or is capable of achieving!

## The Child Watch Visitation Program

The Child Watch Visitation Program is designed to heighten the awareness of a broad range of leaders about the variety and extent of child and family needs. While many people read about the difficulties faced by poor children and families, often it is not until individuals see these challenges for themselves that they become motivated to work for change.

Child Watch participants visit understaffed health clinics with crowded waiting rooms, dilapidated public housing projects where families struggle against drugs and violence, and hospital neonatal intensive care units where one- and two-pound infants fight for each breath.

The participants also visit quality programs that are working successfully to improve the lives of poor children and families. In addition to site visits, program participants receive briefings from

To do our part, CDF is opening a local D.C. child advocacy office. CDF recognizes that our new child advocacy office will be building on, seeking to reinforce, and expanding some of the efforts long under way by many in the District.

I want to extend my deep thanks to these many wonderful advocates and providers working to improve the lives of our city's children. Some of their efforts are described in this book (see What You Can Do for the District's Children, page 147). Others are described by Andrew Carroll in *The Washington, D.C. Volunteer Guide*. Many others have allowed us to see how their programs work or don't work and to see first hand what is being done in this city to save children. We invite you to join CDF's Child Watch Visitation program to see for yourself. Child Watch is designed to make citizens feel the urgency of children's plight in the District. I also salute those within the District government who are struggling mightily to help children despite countless obstacles. They should not give up.

While most of the recommendations in this report address the need for systemic change, there are a number of steps that every Washingtonian can take personally to save children.

policy experts and supplementary written materials. At the conclusion of the Child Watch program, participants discuss the various ways in which they can expand their own efforts on behalf of children.

The Child Watch Visitation model was developed and launched in the District in February 1990. Since then almost 50 local labor, civic, corporate, and religious leaders have participated in the program. In addition, through the development process, CDF became familiar with the many innovative programs that exist in the District and the many committed providers and advocates working on behalf of children.

In May of 1991 CDF began national replication of the Child Watch model, working in partnership with the American Association of Retired Persons, the Association of Junior Leagues, Kiwanis International, the National Council of La Raza, the National Council of Negro Women, and United Methodist Women.

We have more than 800 religious congregations in this city. If each one committed to finding one foster or adoptive family, we could place every child who needs one in a loving family. If they joined together, they could establish family support centers in neighborhoods throughout the city.

We have 4,454 doctors in our city. More could take Medicaid patients or contribute a few hours a week or month to provide preventive health checkups for needy children and help to ensure ongoing health care for all children.

We have three medical schools with medical residents. If the presidents and medical school deans of Georgetown, George Washington, and Howard Universities decided to join in a massive effort with the city and its hospitals to immunize our children, we could reach the Surgeon General's goal of 90 percent for two-year-olds rather than the disgraceful 43 percent at present.

We have one of the most highly educated populations in the country, yet schools and after-school agencies desperately need tutors. Countless child-serving programs need volunteers, board members, money, and support. And while we all have important roles to play, we must finally hold our elected officials accountable for what they do -- not say -- for children locally and nationally.

Finally, I want to thank all the CDF staff who worked long and hard to complete this report, and the foundations whose support of our local District efforts made this report and local project possible. Please address all inquiries on this report to Phyllis Wolfe, the director of the D.C. office, or to her associate, Olati Johnson.

Marian Wright Edelman
President

# Introduction

Washington, D.C., is a city of disturbing contrasts. It is a city of enormous wealth and power but also enormous poverty and despair. It is a city of beautiful monuments, museums, and historic neighborhoods, as well as many abandoned buildings and crack houses. There are three prestigious medical schools within our boundaries and yet more than half of all two-year-old children are susceptible to potentially fatal childhood diseases because they have not been fully immunized. The District's median income of $38,562 for a family of four in Fiscal Year 1991 was higher than those of four-fifths of all states, while its child poverty rate exceeds that of 48 states. Here sits the federal Department of Education that funds innovative programs to enhance educational achievement of the nation's youths, while almost half of all ninth-graders in the District do not graduate from high school four years later, and SAT scores lag 56 points behind the national average.

The headquarters of the world-famous Federal Bureau of Investigation is in Washington, a city that has become infamous as the nation's murder capital. Legal giants debate the issues of liberty and rights at the U.S. Supreme Court here in a city without voting representation in Congress. The District, the capital of the Free World, is also home to the President of the United States. Yet almost 40,000 poor children are not free to realize their fullest potential in the wealthiest and greatest nation on earth.

To become healthy and productive citizens, children need to grow up in safe and secure homes, to be free from abuse and neglect, to have their physical and emotional health needs met, and to be nurtured in families with adequate incomes. Throughout this report you will find evidence that for too many children growing up in the District of Columbia, these basic needs are not being met. These findings illustrate the critical need for strong leadership and broad community support.

## Key Findings

**1. The health and well-being of children in the nation's capital lag behind the rest of the nation. The future of the city is in peril.**

Too many of the city's children are suffering poverty, violence, and despair. Across almost every indicator of health, income, and social well-being, the status of children in the District is abysmal.

- One in three District children lives in poverty -- a rate 40 percent higher than the national average.
- An infant born in the District is less likely to survive until his or her first birthday than a baby born in Cuba or Jamaica.

### How the District Ranks

| **Among States** | |
|---|---|
| Child poverty rate (1985) | 49th |
| Percent of children living in single-parent families (1980) | 51st |
| Infant mortality rate (1988) | 51st |
| Black infant mortality rate (1988) | 35th of 35* |
| Percentage of infants born at low birthweight (1988) | 51st |
| Percent of infants born to women receiving early prenatal care (1988) | 50th |
| Percent of births that are to teenagers (1988) | 49th |
| Percent of teen births that are to unmarried teens (1988) | 51st |
| Juvenile incarceration rate (1987) | 51st |

- The District's black infant mortality rate placed the District last among states and last among the nation's largest cities with measurable black infant death rates.
- Each night 1,300 children sleep in shelters across the city.
- More than 25 children a day are reported abused or neglected.
- Homicide is the leading killer of District one- to 19-year-olds, accounting for almost 60 percent of all deaths in this age group in 1989.
- More than 5,000 juveniles were arrested in 1990.

| | |
|---|---|
| Percentage of annual child support enforcement cases with at least one payment (FY 1988) | 50th |
| **Among Cities over 500,000 Population** | |
| Child poverty rate | 15th of 25 |
| Infant mortality rate (1988) | 25th of 25 |
| Black infant mortality rate (1988) | 19th of 19* |
| Percentage of births that were to teenagers (1988) | 15th of 25 |
| Percentage of teen births that were to unmarried teens (1988) | 22nd of 22* |

* Among cities and states where there were measurable rates.

Sources: U.S. Department of Commerce, Bureau of the Census, *1980 Census of Population*; U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Vital Statistics of the United States, 1988*; U.S. Department of Health and Human Services, Office of Child Support Enforcement, *Child Support Enforcement Statistics, Fiscal Year 1988*; U.S. Department of Justice, Bureau of Justice Statistics, *Sourcebook of Criminal Justice Statistics--1988*. Rankings by the Children's Defense Fund, except juvenile incarceration rate, which was ranked by the Center for the Study of Social Policy.

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- The District's rate of births to unmarried teens is the highest of any state and the highest among 22 of the nation's largest cities.

- The District's overall low-birthweight rate is the highest of any state.

- The District ranks next to last among states in the percentage of infants born to women who received early prenatal care.

**2. Between 1985 and 1989 conditions worsened for the District's children and families.**

- The number of children reported abused and neglected increased by 61 percent (from 6,005 to 9,677).

- The number of juveniles arrested for homicide increased by 320 percent (from 15 to 63).

- The infant mortality rate increased by 12 percent (from 20.7 to 23.1 deaths per 1,000 live births).

- The demand for publicly supported shelter for homeless families more than tripled.

**3. The District has failed to invest in preventive initiatives that could keep children's needs from intensifying and avoid high costs in the future.**

- Only half of the births in the District in 1988 were to women who received adequate prenatal care. Yet every $1 invested in prenatal care saves more than $3 in medical costs in the first year of life alone. In the long term, $1 invested in prenatal care can save as much as $9 in medical, social service, and special education expenditures.

- Each $1 spent to vaccinate a child against preventable diseases saves between $10 and $14 in later costs. But immunization rates for two-year-olds in the nation's capital are as low as those of Third World nations such as Haiti.

- Rather than helping to prevent homelessness, the District shelters and supports many families in dilapidated hotels and motels at a cost of $3,000 a month per family -- almost three times the cost of subsidizing a family's rent and providing support services to prevent homelessness.

- The District places twice as many children in foster care as the national average. It invests virtually nothing in intensive family preservation programs even though the average cost of such programs ($3,000) is far less than the average cost of foster family care ($10,000 a year per child).

### Spending Choices

Preventive investments in children's programs that have been proven to work save public dollars. We can choose to spend:

| | | | | |
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| **$1** | on childhood immunizations | **OR** | **$10** | in later medical costs. |
| **$1** | on comprehensive prenatal care for women through Medicaid | **OR** | **$3.38** | in later health costs. |
| **$1** | for quality preschool education | **OR** | **$4.75** | for later special education, crime, welfare, and other costs. |
| **$765** | per month for homelessness prevention and support services | **OR** | **$3,000** | to shelter a homeless family in a hotel. |
| **$3,000** | per family for family preservation services that help keep families together | **OR** | **$10,000** | for one year of foster family care for one child. |
| **$6,700** | per youth per year for intensive community-based services | **OR** | **$40,000** | to maintain a youth at a juvenile detention center. |

- An estimated 280 youths are maintained in residential treatment programs in distant states, at an average cost of $80,000 per episode. This amount is far in excess of the cost for home-based services and day treatment.

- The High Intensity Supervision Program (HITS) for youths on probation costs one-sixth the amount it costs to detain a child at Oak Hill, the city's maximum security juvenile facility, but the HITS program only has funds to serve 200 youths on probation.

**4. District officials have failed to use all available federal assistance to meet the urgent needs of children and families.**

- Over the past 15 years, the District has failed to spend $47 million in federal housing rehabilitation funds that could have been used to renovate badly needed public housing units.

- The District has failed to take advantage of a cost-effective opportunity to supplement AFDC benefits as a means of ensuring that poor families do not become homeless.

- The city is failing to use Medicaid as it could to develop and staff its comprehensive primary health clinics. Many eligible children and families served by the clinics never get enrolled in Medicaid. Thus the city loses 50 percent federal reimbursement for many of the services it provides.

- By its failure to ensure that children with special medical needs are enrolled in Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, the District is losing millions of dollars in federal funds. The city could be claiming federal reimbursement under Medicaid for many of the services it provides children in the child welfare, juvenile justice, and mental health systems, including many of the more than 250 children in costly out-of-state residential treatment facilities.

- The District is failing to capture an estimated $14 million for which it is eligible under the federal foster care program. These federal funds are available to nelp with the costs of room and board for eligible children, with a range of pre- and post-placement activities, and with training for foster and adoptive parents and staff.

**5. Severe shortages of qualified staff across human service agencies jeopardize the care children receive.**

- Lack of staff, particularly public health nurses, in the city's neighborhood health centers threatens primary health care to all who need it. A 1990 CDF survey found the average waiting time for a prenatal care appointment in the clinics to be nearly three weeks. Staff shortages also prevent children from getting their necessary immunizations. Only one of the city's 15 clinics has evening hours, and that is only because Commission of Public Health staff volunteer their time.

- Chronic staff shortages have persisted for years in the Child and Family Services Division, which is charged with caring for abused and neglected children. As of April 1991, 45 percent of the Division's positions were vacant. Staff members race from crisis to crisis, unable to provide even a minimum level of care to the children they are charged with protecting.

- With more than 150 vacancies in the Income Maintenance Administration, it is difficult for workers to comply with federal case processing timelines and nearly impossible to provide the individualized attention many families that apply for AFDC need. The lack of trained staff in the food stamp program to do outreach and accurately advise people of their rights contributed to a 19 percent decline from 1985 to 1989 in the number of persons receiving food stamps.

- In the city's youth detention facilities, overtime payments made up one-fourth the total staff expenditures in 1989. Overworked staff members have little time or capacity to respond to the individual needs of the young people for whom they are responsible, and overtime dollars divert resources from other important services.

**6. Poor management practices impede the effective delivery of services to children and families.**

- Across-the-board freezes on hiring have been implemented indiscriminately, with the result that they have not only harmed children and families but failed to achieve the desired cost savings. Freezes have hurt a number of cost-effective programs such as prenatal care, AIDS prevention, child support enforcement that generates revenue, and substance abuse treatment initiatives.

- Centralized and inefficient procurement of services, equipment, and supplies causes inordinate delays in program implementation, thwarts program improvements, and frequently results in wasteful last-minute purchases on an emergency basis.

- Child-serving agencies in the District rarely communicate as they develop budgets or implement programs, even when they serve the same children and families. The failure to coordinate services leads to fragmentation, needless duplication, and inefficient use of available federal funding.

**7. Lack of investment on the part of national leaders has short-changed the city's future in both human and fiscal terms.**

- At the national level we have chosen not to engage the enemies of poverty, violence, and family disintegration that pose at least as great a threat to our children and future national security as any foreign enemy. While President Bush and Congress found a way to put thousands of troops and support personnel in Saudi Arabia within a few months to fight Saddam Hussein, they have been unable and unwilling to mobilize hundreds of teachers, doctors, nurses, and social workers for desperately underserved inner cities, including our own.

- The poor status of children in the District is exacerbated by the city's dependent relationship to the federal government. The low federal payment has strangled the city financially and affected its ability to deliver services to children. Although important help is in sight, more is needed. While the city enjoys some measure of "home rule," any significant budget and spending decisions are subject to the approval of Congress and the White House. The results are drawn-out budget battles and political gamesmanship, while thousands of children's needs go unmet. The city too must struggle alone without help from a state or more affluent suburbs.

## Major Recommendations

We understand the frustration many in government feel about repeated attacks from "outsiders." We recognize and applaud the many committed workers, managers, and directors of programs who do the best they can with limited resources despite the bureaucratic barriers and inconsistent leadership and policy direction over which they too seldom have control and input. Many city employees are summoned into court to explain why children are mistreated; they also have their programs probed, analyzed, and criticized in numerous reports. Despite these stressful circumstances, they continue to exert themselves on behalf of children and families. But they need more help. They need the support of every citizen and they need a commitment by public and private leaders to place children at the top of the community's agenda.

Blame for the plight of children in the District does not rest solely with government, either national or local. All of us who live or work in the District, who take justifiable pride in our nation's capital, who enjoy its museums and parks, must also take responsibility for our human treasures -- our children. We can no longer pretend that our private lives and our neighborhoods can remain untouched by the diminished hopes of one-third of the District's children. We cannot remain two cities and live a peaceful co-existence. The children of poverty and the children of privilege share a common destiny unfolding in the District just as they do in the nation. All own a piece of the American Dream. All will be future workers and leaders or dependents. We simply cannot afford to lose any more children to poverty, drugs, too-early childbearing, and violence.

### A District Child's Chances of Being Poor

| | |
|---|---|
| If white | 1 in 20 |
| If black | 3 in 10 |
| If Latino | 1 in 4 |
| If Asian American | 1 in 5 |
| If Native American | 1 in 3 |
| If in a female-headed family | 2 in 5 |
| If younger than six | 2 in 7 |
| If six to 17 | 1 in 4 |
| If living in Ward 1 | 2 in 7 |
| Ward 2 | 3 in 8 |
| Ward 3 | 1 in 25 |
| Ward 4 | 1 in 10 |
| Ward 5 | 1 in 4 |
| Ward 6 | 2 in 7 |
| Ward 7 | 1 in 3 |
| Ward 8 | 1 in 3 |

Source: Related children in families from the Census of 1980, poverty based on 1979 income. The Census Bureau will release comparable detail from the Census of 1990 in 1993. Calculations by the Children's Defense Fund.

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## Make Children a Community-Wide Priority

Every sector of the community must commit publicly to investing in children and families and back up that commitment with sustained action. Many in the community already have taken active roles. Some of their efforts are described in this book (see What You Can Do To Help the District's Children chapter). But others have been watching from the sidelines or simply ignoring the problems our children face.

While the recommendations found in the report that follows are geared to public policy changes, we are poignantly aware that a fiscally depleted local government must be able to depend on the rich resources that exist within the unique Washington, D.C., community. Our most respected community leaders and the corporations, foundations, universities, hospitals, and federal agencies they represent have a special role and a special responsibility toward children in the District. If we are to create real change on behalf of children, each of these institutions must make its own individual contribution.

- Leadership from the federal government is critical to change for the District's children. Such leadership can go far beyond financial resources, important as these are. The federal government must acknowledge its role as the single largest employer in the District by supporting innovative approaches to training for public sector and nonprofit agencies; encouraging employees to participate in community activities through release time; and expanding loaned executive programs and staff exchanges with the District government. It must seek to make the District a showcase of what we as a nation can accomplish for our children by targeting demonstration grants to public and private child-serving agencies.

- Major corporate employers and other businesses must join with the District government and nonprofit agencies to develop training and jobs programs that will improve access for the District's parents to well-paying employment. The business sector must promote family-centered policies, such as child care assistance and paid family and medical leave. Businesses should also focus their human and fiscal resources on a particular school, community organization, or neighborhood. Employees should be encouraged to work with child-serving programs and schools.

- Universities, hospitals, foundations, and research and policy institutes can make a wide variety of contributions to the circumstances of children in the District, whether through staff exchanges, financial resources, innovative joint ventures, technical assistance, public education activities, or actual targeted campaigns such as immunization efforts.

- Representatives of religious institutions, civic and social organizations, and individual citizens can select from a continuum of projects ranging from mentoring and tutoring, providing respite care for foster parents, or participating in adopt-a-family programs to the creation of low-income housing and family support programs.

## Make Children a Top District Government Priority

Mayor Dixon, both before and after her election, has affirmed her belief that children always have been "at the bottom end of the ladder in the city," and that only new leadership will give them a higher priority. Mayor Dixon and her cabinet and agency leadership must renew that commitment in order to galvanize both public and private efforts to bring about systemic change. We understand the tax burden borne by District residents, and we acknowledge that this new administration has inherited an entrenched system and a backlog of problems that have evolved over a decade. But our public systems for children must be fixed now before another generation of children is left at risk. To demonstrate her commitment, Mayor Dixon must revamp the District's services to children and families in four key ways.

### *1. Invest in prevention*

The District must invest in services and supports that will prevent problems from intensifying and will reduce costly expenditures for crisis and remedial care. Most poor children, even those living in families under great stress, can be helped if their problems are identified and addressed before they become serious. A preventive investment agenda is the key to serving our city's long-term fiscal health.

This means ensuring investments in prenatal care to prevent the costly treatment of birth defects, immunization to prevent the need to treat many diseases, family support programs to enable parents to protect their children and prevent abuse and neglect, rent subsidies and rehabilitation of existing housing units over costly welfare hotels, and community-based alternatives over costly detention centers for juveniles. In her FY 1993 budget, Mayor Dixon must make a down payment on a preventive investment agenda that reflects new choices for the city. The down payment must include an increase estimated at $15.9 million over the base budget, for the following critical programs:

- Expand four neighborhood health clinic hours by 20 hours each: $4 million.

- Select and carry out moderate rehabilitation on 250 two-bedroom units of public housing: $4.5 million.

- Develop therapeutic foster homes for 350 children with special needs: $5.2 million.

- Reinstate AFDC benefits cut in 1991 for present and projected FY 1992 recipients: $2.2 million.

### *2. Improve agency performance*

Life for many of the District's children and families will change little until management and budget practices are reformed. Our findings indicate the need for improvements in the budget development and implementation process and in procedures for program management. Mayor Dixon and her key public administrators must take immediate steps to ensure that the budget process encourages program managers to consider the real needs of children and families, especially where those needs cross multiple agencies. They must reject indiscriminate hiring and spending freezes that jeopardize cost-effective programs. And they also should implement a mechanism to enhance interagency coordination for individual children as well as for overall policy.

### *3. Capture every dime of federal resources for children*

Mayor Dixon *must* capture all the federal assistance available for child health, child welfare, and housing programs and reinvest all of these dollars in preventive and community-based programs for children and families. Consultants from the federal government and the private sector should be enlisted to work with agency staff and expedite the process, in order to move immediately to claim all available funds through Medicaid, the federal Foster Care and Independent Living programs, the Supplemental Security Income Program, and the Child Support Enforcement Program. The city could receive an estimated $14 million by maximizing funding under the federal Foster Care Program alone that could be used to enhance services for children in the foster care system. Procedures must be implemented to facilitate appropriate future claims. Any federal funds received should be re-invested in early intervention, prevention, and community-based services.

### *4. Address the staffing crisis*

As Mayor Dixon seeks to correct the bloated city bureaucracy, she also must assess the tremendous staffing gaps in the systems that are responsible for serving children and families. Agencies with high vacancy rates are unable to deliver high-quality services to children. New staff must be hired and in some cases existing staff retrained. On-

## Who Are the District's Children?

### Total child population

- There are 117,092 children younger than 18 living in the District, a decrease of 18 percent since 1980.
- There are 44,174 children younger than six and 72,918 children ages six to 17.

### By race and ethnic origin

- Eighty percent of the child population is black, 15 percent is white, 1 percent is Asian, and 6.2 percent of the child population is Latino.
- While there has been a 24 percent decrease in the black child population, there has been a 95 percent increase in the Latino child population since 1980.

### Family households by type

- The majority (51 percent) of all households with children in the District are headed by females. Nearly 60 percent of black households with children are female-headed, while only 15 percent of all white households with children are female-headed.
- The majority of all Latino households with children (59 percent) are married-couple households. Thirteen percent of all Latino households, however, are single-parent households with male heads, and 29 percent are female-headed.

Note: Latino persons may be of any race.

Source: 1980 Census of Population, General Population Characteristics and 1990 Census of Population, Summary Tape File 1. These data have not been adjusted for undercounts. Calculations by the Children's Defense Fund.

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going training and supports also are needed. Mayor Dixon should give immediate priority for increased staffing to child protective services and other parts of the Ambulatory Health Care Administration, the Child and Family Services Division, and the Income Maintenance Administration. Area universities and personnel departments of corporate offices -- with possible foundation support -- could help in recruitment and retention efforts to keep positions filled with trained and qualified staff.

## Urgent First Steps

As critical as these approaches are to basic change in the lives of the District's children, we cannot afford to wait for needed systems change -- better management, better collection of federal resources, and better staffing -- to start making a difference. At the rate children are dying in the District, every week, day, and hour count. Therefore, we must move *immediately* to remedy the emergencies that put children at risk today -- at the same time that we are laying the foundation for better systems that will prevent them from being at risk tomorrow.

The total net cost of our emergency recommendations is $1,950,000.

### Get Our Children Immunized Now

**Goal:** To ensure that 90 percent of all children two years old and younger are immunized by October 1992.

It is disgraceful that only 43 percent of District two-year-olds are adequately immunized. In contrast, more than 90 percent of children in licensed child care and in schools are immunized. While children catch up on their vaccinations by school entry, immediate efforts must be made to reach children two and younger. Vaccinations must be given at specific intervals throughout the preschool years, which requires continuous outreach and follow-up, personnel that can work flexible hours, and expanded clinic hours.

The public health centers are understaffed and do not have the necessary resources to target preschoolers. Commission of Public Health (CPH) staff members volunteer their own time to open evening hours in one clinic. However, the flexible staffing needed to reach the youngest children requires a permanent staff to support basic activities.

To meet the goal the mayor must take the following actions:

- ***Establish an immunization team:*** A team of two pediatric nurse practitioners, a registered nurse, and an administrative clerk should be hired and assigned to the Division of Immunization. This office distributes all vaccines and works with the public health clinics. They can develop special outreach activities that range from ongoing efforts to bring children in for timely vaccinations to home visits to ensure children are properly immunized.

- ***Extend hours at designated clinics specifically for immunizations:*** Additional evening hours are required to support the more burdened public health centers. In addition, a permanent evening pediatric clinic must be established. The staff would be available to work with volunteer health professionals and nursing students in these added hours.

- ***Appeal to the community to assist the public health system:*** The mayor should convene the two medical societies, the Academy of Pediatricians, medical school deans, and hospital administrators to encourage all health professionals to become Medicaid providers and accept a fair share of low-income patients. Local churches and other community organizations should engage actively in educating District residents on the importance of timely immunizations and the value of preventive health.

Cost: It is estimated that $200,000 a year is necessary to staff and equip the immunization team.

### Move Homeless Families Out of Hotels

**Goal:** To discontinue using hotels to shelter children and families even on a temporary basis, by July 1, 1992.

It is unacceptable that more than 200 homeless families a night still are being sheltered in hotels at a cost of more than $3,000 per family per month, almost six times the cost of subsidizing a family's rent. While these costly and inhumane hotels must be closed, no family should be left out on the street. The District must work aggressively with the federal Department of Housing and Urban Development (HUD) to acquire rent subsidies and also should provide additional District-funded subsidies for families in hotels. In addition, the city should move forward with its plans to work with local nonprofit providers, such as MUSCLE and Community of Hope, to establish quality apartment-style shelters with appropriate services in scattered sites for those families that do become homeless.

**Cost:** The District has not added any new rent subsidies under the Tenant Assistance Program for at least two years. The city should demonstrate a commitment to discontinue the use of hotels to shelter homeless families by funding 125 new subsidies and should request that HUD provide the city with 125 additional certificates under the Section 8 Program. The estimated cost of these subsidies to the city would be $750,000.

## Protect Children by Strengthening Families

**Goal:** To offer enhanced support to families by establishing immediately a fully staffed Family Preservation Service (FPS) Unit.

The District's current child welfare system spends money on families' problems after they intensify, rather than on less costly prevention services that can strengthen families and protect children. In 1990 the District was spending almost $36 million to maintain children in substitute care settings, but very little to strengthen and preserve families

### A Portrait of the District's Children

By any measure, tens of thousands of District children live a fearsome existence:

- Every 56 minutes a District child is reported abused or neglected (9,417 reports in 1990).
- Every 100 minutes a District child is arrested (5,250 juvenile arrests in 1990).
- Every four hours a District teenager gives birth (2,100 births to women younger than 20 in 1989).
- Every five hours a baby is born in the District weighing less than 5.5 pounds (1,862 low-birthweight births in 1989).
- Every nine hours a juvenile is arrested for selling drugs (978 juvenile arrests in 1990).
- Every 20 hours an arrested juvenile tests positive for cocaine

before placement became necessary, even though the least expensive placements cost on average three times more than intensive family-based services.

The mayor immediately should establish a Family Preservation Unit that would allow families to be stabilized and avoid the costs for unnecessary out-of-home placements. This unit eventually should act as a gatekeeper for children at risk of placement in the child welfare, mental health, and juvenile justice systems. The model program described in detail by the Center for the Study of Social Policy in its September 1990 report on the District's child welfare system requires well-trained workers with caseloads of four or fewer families to work intensively with a family for no more than six weeks, seeking to address their immediate needs and to link them with community resources. Five units, each of which would include a supervisor and five staff members, serving an estimated 560 families per year, should be established over the next 12 months.

use (431 positive test results among arrested District juveniles in 1990).

- Every 33 hours a District infant dies (267 infant deaths in 1989).
- Every three days and three hours a person younger than 21 is murdered (117 homicide deaths of children younger than 21 in 1990).
- Every night more than 1,300 children languish in the District's homeless shelters (637 families, including 1,387 children, in July 1991).
- Every day 34,900 District children lived in poverty (in 1986, 30 percent of all children younger than 18 were poor; among persons 18 to 64, 13 percent were poor).

Sources: Department of Human Services, Office of Policy and Planning, Research and Statistics Division, District of Columbia Government; 1990 Crime and Justice Report for the District of Columbia, Office of Criminal Justice Plans and Analysis, District of Columbia Government, June 1991; Washington Legal Clinic for the Homelessness; Census '86, Greater Washington Research Center, and analyses of that data by the Office of the Special Assistant for Human Resource Development. Some calculations by the Children's Defense Fund.

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**Cost:** The Center for the Study of Social Policy estimates the first- and second-year costs of the program to average just over $1 million each year, and these costs would be offset in large part by reductions in out-of-home care costs. By the end of the second year the program will yield more than $2 million in savings. The units should be phased in over the next year, with at least three of the first units of five workers established within six months. Approximately 300 families should be served by October 1, 1992.

### Support Interagency Collaboration

**Goal:** To facilitate service delivery for children with multiple needs who are involved with multiple agencies by establishing an Interagency Board by January 1992.

A pilot effort in interagency collaboration between public and private child-serving agencies has evolved in the District over the past two years. With Mayor Dixon's leadership, an Interagency Board should be established permanently that links the Department of Human Services, the D.C. Public Schools (DCPS), and the D.C. Superior Court to better serve the city's children with multiple needs. The board should identify service gaps, develop service approaches that reach across systems, and recommend common policies and practices for different agencies. The board also should review individual cases of children involved with multiple agencies and recommend and secure appropriate treatment to meet their needs. A minimum of 20 cases should be reviewed by the board in the first year.

**Cost:** It is anticipated that $100,000 a year would pay for staff support and computer equipment and provide discretionary funding to purchase special services. Each of the major agencies involved should contribute to the Board's budget.

## The Long-Term Agenda: A New Public/Private Entity

To ensure long-lasting change for children, we must focus on the opportunities that are at hand. There is new leadership in key positions -- the mayor and her cabinet, the city council, a new congressional representative, and a new superintendent of the public school system. There is renewed support from Capitol Hill. There also is a resurgence of volunteerism and community participation.

The mayor must reach out to the community for help. The mayor must look beyond the already beleaguered public systems to help the city strengthen its role as protector of children. Mechanisms must be created to forge new alliances between the public and private sector and to funnel the expertise, resources, and support in the community to assist local government in instituting reforms for children. The blueprints for change for children and families have been laid out, but the implementation of these plans must be guided and measured.

We recommend that Mayor Dixon seek and support the establishment of a public/private entity with a mandate to garner diverse community resources to assist her administration in revamping the systems that serve children and their families. Many major cities have developed special nonprofit entities that have served as intermediaries in strengthening the public system's capacity to deliver human services. Examples of such partnerships are the Ford Foundation-initiated Fund for the City of New York, the Annie E. Casey Foundation-supported Partnership for Kentucky School Reform, and the Rockefeller Foundation's Poverty Initiatives. With an infusion of private funds, the partnership will be able to offer support through strategic planning sessions, ongoing consulting, management assistance, staff exchanges, and training institutes. This partnership must have the capacity to distribute funds for innovative special initiatives and document and reward progress made on behalf of children and families.

The mayor has access to a talent base that is unique to the Washington, D.C., metropolitan area. Local corporations, universities, foundations, nonprofit providers, and management, policy, and research organizations can be called upon to assist in creating a partnership that is tailored to the District's needs. At a time when everyone has "too much to do," the partnership is empowered to focus on making a difference for the District's children. Children cannot wait.

## Where We Live

**Ward 1:**
Population (1988): 77,500
Blacks (1986): 57 percent
Whites (1986): 30 percent
Latinos (1986): 16 percent
Median household income (1985): $18,900
Children younger than 18 (1986): 13,700
Poor children (1985 income): 5,800
Child poverty rate (1985 income): 42.3 percent
Infant mortality rate (1985-89): 20.6 deaths per 1,000 live births

**Ward 2:**
Population (1988): 80,900
Blacks (1986): 46 percent
Whites (1986): 43 percent
Latinos (1986): 8 percent
Median household income (1985): $23,000
Children younger than 18 (1986): 9,500
Poor children (1985 income): 2,900
Child poverty rate (1985 income): 30.5 percent
Infant mortality rate (1985-89): 21.7 deaths per 1,000 live births

**Ward 3:**
Population (1988): 77,600
Blacks (1986): 7 percent
Whites (1986): 86 percent
Latinos (1986): 6 percent
Median household income (1985): $37,700
Children younger than 18 (1986): 10,600
Poor children (1985 income): 300
Child poverty rate (1985 income): 2.8 percent
Infant mortality rate (1985-89): 9.9 deaths per 1,000 live births

**Ward 4:**
Population (1988): 80,300
Blacks (1986): 87 percent
Whites (1986): 9 percent
Latinos (1986): 4 percent
Median household income (1985): $24,000
Children younger than 18 (1986): 13,200
Poor children (1985 income): 2,300
Child poverty rate (1985 income): 17.4 percent
Infant mortality rate (1985-89): 18.3 deaths per 1,000 live births

**Ward 5:**
Population (1988): 80,100
Blacks (1986): 93 percent
Whites (1986): 6 percent
Latinos (1986): 3 percent
Median household income (1985): $20,300
Children younger than 18 (1986): 14,200
Poor children (1985 income): 3,800
Child poverty rate (1985 income): 26.8 percent
Infant mortality rate (1985-89): 23.8 deaths per 1,000 live births

**Ward 6:**
Population (1988): 73,400
Blacks (1986): 69 percent
Whites (1986): 30 percent
Latinos (1986): 2 percent
Median household income (1985): $21,700
Children younger than 18 (1986): 12,600
Poor children (1985 income): 4,400
Child poverty rate (1985 income): 34.9 percent
Infant mortality rate (1985-89): 23.9 deaths per 1,000 live births

**Ward 7:**
Population (1988): 78,300
Blacks (1986): 95 percent
Whites (1986): 5 percent
Latinos (1986): 3 percent
Median household income (1985): $18,200
Children younger than 18 (1986): 20,500
Poor children (1985 income): 6,700
Child poverty rate (1985 income): 32.7 percent
Infant mortality rate (1985-89): 21.7 deaths per 1,000 live births

**Ward 8:**
Population (1988): 74,500
Blacks (1986): 90 percent
Whites (1986): 9 percent
Latinos (1986): 3 percent
Median household income (1985): $17,800
Children younger than 18 (1986): 22,200
Poor children (1985 income): 8,700
Child poverty rate (1985 income): 39.2 percent
Infant mortality rate (1985-89): 24.7 deaths per 1,000 live births

Sources: Indices, Office of Policy and Program Evaluation, District of Columbia Government; Census '86, Greater Washington Research Center, and analyses of that data by the Office of the Special Assistant for Human Resource Development, District of Columbia Government; Department of Human Services, Office of Policy and Planning, Research and Statistics Division, District of Columbia Government. Some calculations by the Children's Defense Fund.

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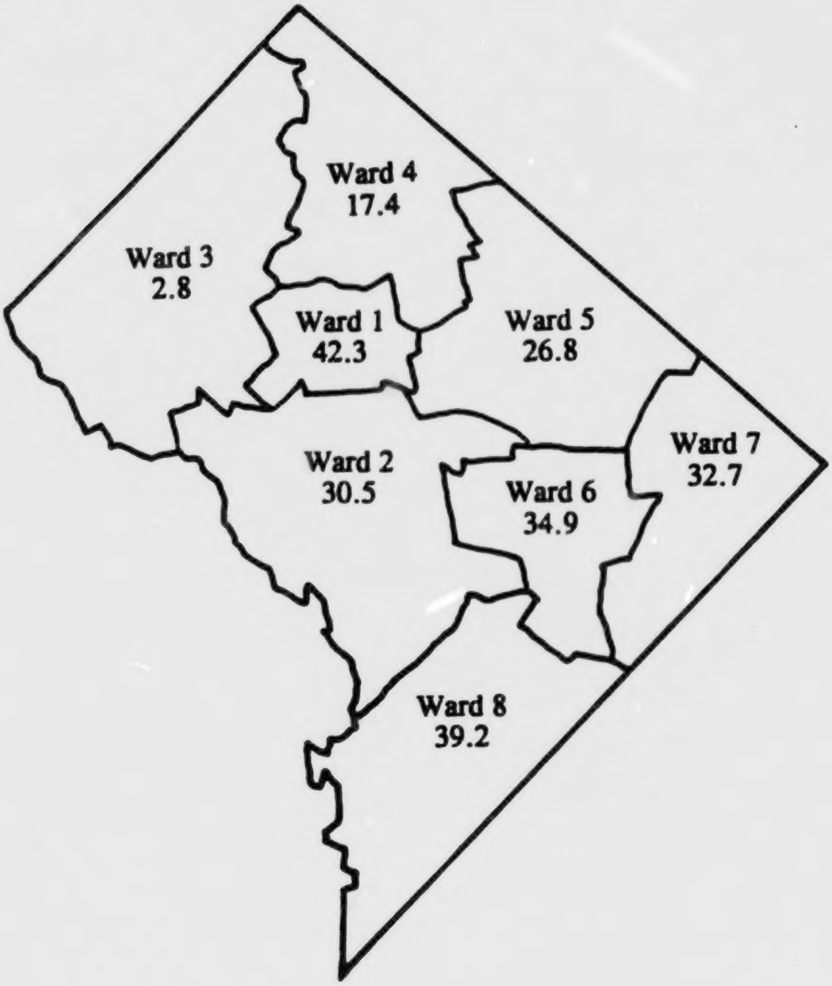
## Percentage of District Children Living in Poverty, 1985



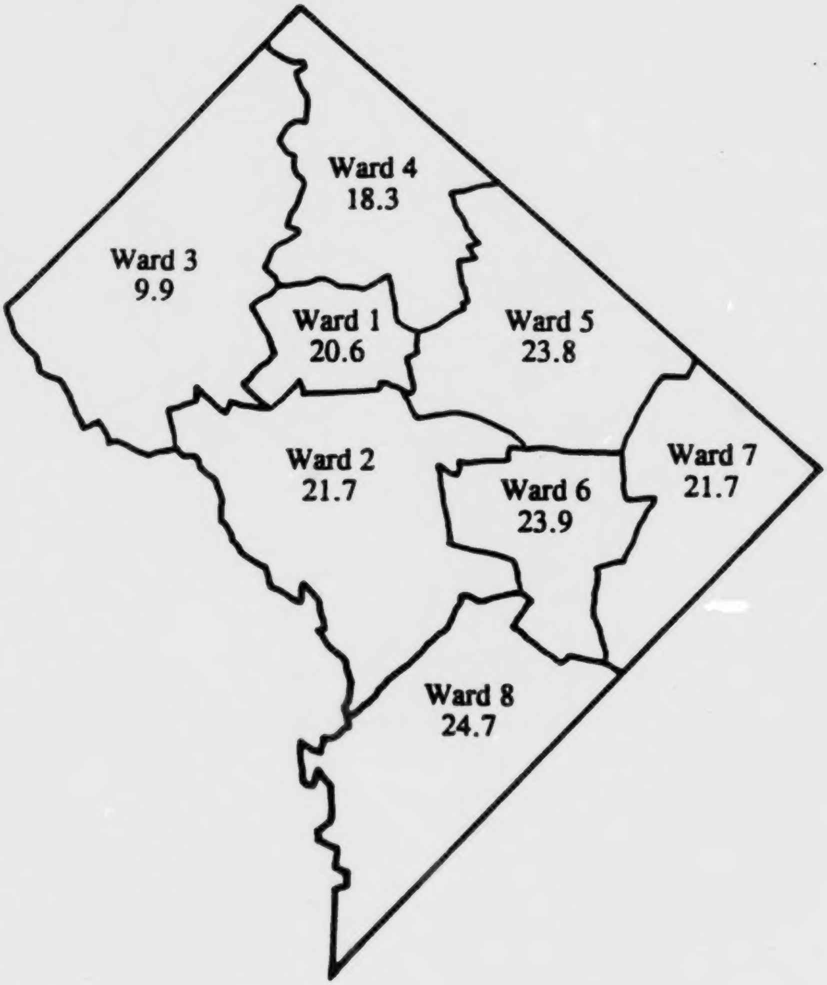
A child living in Ward 1 is 15 times as likely to be poor as a child living in Ward 3.

While 300 poor children live in Ward 3, 8,700 live in Ward 8.

Source: Census 1986, Greater Washington Research Center, and analyses of that data by the Office of the Special Assistant for Human Resource Development, District of Columbia Government. Calculations by the Children's Defense Fund.

## Infant Mortality Rates in the District of Columbia, 1985-1989

(Deaths per 1,000 live births)



A child living in Ward 8 is two-and-one-half times as likely to die before his or her first birthday than a child living in Ward 3.

Source: Department of Human Services, Office of Policy and Planning, Research and Statistics Division, District of Columbia Government. Calculations by the Children's Defense Fund.

# Summary of Findings and Recommendations

This section summarizes our key findings about the circumstances of the District's children and our recommendations for public policy actions to reshape those circumstances dramatically. Because our study focused closely on the daily lives of our city's children and the immediate public policies that help or neglect them, we offer here primarily recommendations for public action by the District of Columbia.

But the problem and the solutions are clearly much broader than that. The concluding chapter of this book, What You Can Do for the District's Children, emphasizes that each of us has a responsibility to take concrete and immediate action to help children.

## Maternal and Child Health

### Findings

**Many District children and families lack access to quality preventive health care. The health status of black mothers and children in the District is among the worst in the nation -- compared not only with white mothers and children but with black mothers and children in other cities and states. In key indicators of access to basic health care -- infant mortality and low birthweight -- the District ranks poorly.**

- The District's 1988 overall infant mortality rate of 23.2 deaths per 1,000 live births was worse than all 50 states and more than twice the national rate of 10.0 deaths per 1,000 live births.

- The District's black infant mortality rate placed it last among states and last among the nation's largest cities with measurable black infant mortality rates.

- The Centers for Disease Control reported in 1990 that the District's infant mortality rate has been rising by 1.6 percent a year since 1984 – a trend unparalleled anywhere else in the nation.

**Despite the fact that every $1 invested in prenatal care saves more than $3 in medical costs in the first year of life alone by averting low birthweight, many pregnant women in the District do not have access to prenatal care.**

- Only 61.2 percent of all District infants were born in 1988 to women who received early prenatal care in the critical first three months of pregnancy, compared with 75.9 percent nationally.

- Only half (51.3 percent) of all 1988 births in the District were to women who began prenatal care early and had enough prenatal care visits. For black infants the percentage was 46.0 percent; for white infants it was 81.3 percent.

**If they survive infancy, children in the District face a significantly greater risk of illness and death from preventable diseases than children nationwide.**

- Only 43.2 percent of all District two-year-olds are immunized against preventable childhood disease, compared with an already shockingly low national rate of between 70 and 80 percent. Infant immunization rates in the nation's capital are no better than in Third World nations such as Haiti, even though each dollar spent to vaccinate a child saves up to $14 in later costs.

- The city's 1981-1985 mortality rates from natural causes among children ages one to four and 10 to 14 were the highest in the nation, and many of the causes of these deaths were preventable.

- Children from the city's poorest neighborhoods are hospitalized for preventable illnesses at two to three times the average Washington, D.C., metropolitan rate.

**The District is among the cities in the nation with the highest incidence of women and children with the AIDS-causing HIV virus.**

- A recent Centers for Disease Control report found that in 1990 one in 74 births in the city (more than 1 percent of all births) was to a woman infected with the HIV virus. As of December 1990, 35 cases of pediatric AIDS (AIDS in children younger than 13) had been reported in the District, up from 28 cases the previous year.

- AIDS and other sexually transmitted diseases are increasing threats to teens in the District. As of December 1990, 122 young adults ages 20 to 24 were diagnosed with AIDS, and many of them likely were infected as adolescents. The number of syphilis cases among young people ages 10 to 24 more than doubled between 1987 and 1988, which indicates the youths also face an increased risk for HIV infection.

**Substance abuse and violence are threatening the lives of all of the District's children.**

- In 1989 drugs were implicated in 958 emergency room visits involving children ages six to 17.
- In 1989 homicide was the leading killer of District youths. Seventy-one District teenagers ages 15 to 19 were murdered in 1989, accounting for three-quarters of all adolescent deaths in that year.

**Thousands of District children and families lack health insurance. Poor children without health insurance are most likely to lack a regular source of care. They often miss preventive visits and immunizations and must rely on inappropriate sources for primary care, such as hospital emergency rooms.**

- An estimated 25,000 children in the city – one in six – had no health insurance in 1987. Poor residents are twice as likely as nonpoor residents to be uninsured.

**The city has failed to mount a comprehensive primary health initiative for children. The District has failed to maximize federal revenues for health services under the Medicaid program.**

- The District has a severe shortage of Medicaid providers due in part to low payment rates and a dearth of providers in neighborhoods where large numbers of poor families reside.
- Although the District has taken important steps to extend Medicaid eligibility to pregnant women and infants with family incomes up to 185 percent of the poverty level, multiple barriers, such as lengthy and complex enrollment procedures, prevent these women and infants from enrolling in the program and from receiving the preventive health services funded under Medicaid. Families are required to apply for Medicaid at welfare offices, rather than at hospitals and community health centers where they are more likely to go for health care.

- The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is the gateway to health care for Medicaid-eligible children. EPSDT is designed to provide all children younger than 21 with comprehensive health screening exams and treatment for conditions identified through the exams. Yet in 1989 the District was providing just 21 EPSDT screening exams for every 100 Medicaid-eligible children. Children who do not get exams are denied necessary services for conditions that might have been identified.

- The city also has failed to implement EPSDT reforms that could help pay for services currently being provided to children in the care of the city's child welfare and children's mental health agencies.

**Although the need for public health services is greater than ever before, there has been a sharp drop in the number of patients seen in the health clinics.**

- A 1990 survey of the city's health clinics by CDF found that despite the Commission of Public Health's announced policy of guaranteeing every pregnant woman an appointment within two weeks, the average waiting time for an appointment was nearly three weeks. One clinic did not have an opening until 39 days later.

- Because of understaffing, only one of the clinics currently has evening hours, and in that case it is staffed by top-level Commission of Public Health personnel volunteering their own time.

- The deterioration of the physical condition of the clinics has resulted in limited services. Some clinics have no choice but to close when the weather is extremely hot or cold. Inadequate waiting areas, crowded work spaces, and peeling paint affect the morale of both staff and patients.

**Despite the devastating impact of a grossly inadequate clinic system, the city has continued to reprogram badly needed funds from the public health clinics to other District programs and failed to use federal Medicaid dollars appropriately to maintain clinic budgets.**

- The city has failed to capture Medicaid funds that could be used to reimburse clinics for the full cost of serving Medicaid patients, and to allow clinics to retain the revenues that are generated to hire staff and expand services. Overworked clinic staff often do not bill Medicaid for services provided to Medicaid-covered patients, resulting in the city's losing valuable federal matching funds equal to 50 percent of the cost of the services.

**Recommendations**

**Increase investments in prevention.**

- Fully immunize all children. Relieve pressure on the clinics by providing vaccine to private physicians free of charge. More clinic staff must be hired to administer inoculations to children in a timely manner and to conduct outreach campaigns to parents and community-based organizations.

- Expand the neighborhood clinics. Maternity and pediatric clinics must maintain evening and weekend hours to accommodate the needs of working families. Staffing levels must be increased to assure that all residents seeking care can receive quality medical services.

- Enhance prenatal care. The District can enhance benefits to pregnant women covered by Medicaid to include services that address a family's psychological and social needs, not just medical needs. These benefits include care coordination, risk assessment, nutritional counseling, parenting education, and home visiting.

- Implement federal EPSDT reforms. All of the city's Medicaid-covered children should receive routine preventive health assessments through EPSDT, and the services necessary to address problems identified through the exams. Quick implementation is especially important to children with chronic illnesses or disabilities with extensive medical needs, including those in the care of the city's child welfare and mental health agencies.

- Provide treatment services to drug and alcohol dependent women. Too few substance abuse treatment programs are available for pregnant women or women with children. Inpatient and residential treatment programs especially are needed to provide comprehensive intensive services, including prenatal care and postpartum and pediatric care, child care, nutrition assistance, and a range of other supportive services.

**Simplify Medicaid enrollment.**

- Simplify the Medicaid application for pregnant women and children. Currently, the Medicaid application is 10 pages long and discourages many eligible families from submitting a completed application. A one- or two-page application form would be far less intimidating and confusing to applicants.

- Place Medicaid eligibility workers in all publicly funded health clinics and hospital outpatient clinics. More families will enroll if Medicaid can be sought at the same time and in the same places as health services. It also will help the clinics recoup some of the costs of services provided.

- Develop Spanish-language applications to facilitate participation by Latino families. Culturally sensitive outreach programs should be developed to encourage Medicaid participation and preventive health care use.

**Maximize federal Medicaid revenues.**

- Increase Medicaid reimbursement for clinic services. Enroll in Medicaid all eligible patients who use the neighborhood clinics, and routinely bill Medicaid for the services they receive. This would allow the District to recoup funds that then should be used to help operate the clinics, expand services, and hire more staff.

- Enroll all eligible children in Medicaid. The District should provide active outreach, through schools, churches, day care, Head Start, and other child-serving programs, to enroll Medicaid-eligible children.

## Housing and Homelessness

### Findings

**During the 1980s the District experienced a large increase in homelessness among families.**

- Between 1985 and 1989 the demand for publicly supported shelter services (the number of nights families spent in shelter) more than tripled. As of the end of July 1991 there were 637 homeless families, including 1,387 children, in city-operated or -supported shelters.

- More than 200 of these families, including 400 children, are sheltered by the city in costly hotels and motels. Most are sheltered and supported at a cost of about $3,000 a month per family, although many would require less than $500 a month in housing assistance to retain permanent housing.

- More than one-third of all District children live in doubled-up households, some of them on the brink of homelessness.

**Increasing poverty among families, a decreasing supply of low-cost housing, and insufficient assistance from federal and local governments all have contributed to the rise in homelessness among families.**

- In 1985 the Low Income Housing Information Service estimated that there were 46,545 low-income households competing for 14,866 affordable units, a gap that certainly has widened since then.

- A moderately priced two-bedroom apartment in the District costs $731 a month, according to the U.S. Department of Housing and Urban Development (HUD). This amount is not affordable for many District families: a full-time, minimum wage job yields about $640 a month and the maximum Aid to Families with Dependent Children (AFDC) grant for a family of three in 1991 was only $409 per month.

- Underassessments of commercial real estate cost the city $146 million in tax revenues between 1986 and 1989, an amount that could have been used to develop more low-cost housing.

- Many low-income families get no help with their housing costs.

  - About two-thirds of Washington, D.C., area households with annual incomes of less than $10,000 and 85 percent of those with incomes between $10,000 and $20,000 received no help with their housing costs in 1985.

  - About 11,800 families reside in public housing in the District, while more than 11,394 are on the waiting list. Meanwhile, more than 2,300 public housing units are vacant and uninhabitable because they need repairs.

  - Poor households in the District spend an average of 68 percent of their incomes for housing. This is far in excess of the recommended 30 percent, and more than three times the average amount spent by District-area households.

- Many families become homeless because of overcrowding or other bad housing conditions, such as inadequate heating, peeling paint, lead dust, and faulty electrical systems.

**Homelessness takes a tremendous toll on the health, education, and development of children.**

- Homeless children lack basic preventive health care. They also suffer because of the crowded and unsanitary conditions in the shelters and because of the shelters' unreliable and nutritionally unstable feeding arrangements.

- Homelessness can damage children's educational development irreparably. The uncertainty, chaos, and emotional stress of their everyday lives impede their learning. Young children often are delayed developmentally. Transportation and other barriers keep children out of school.

- Homelessness often separates family members. Some shelter rules exclude family members. Often parents may send older children away to friends or relatives to spare them the horrors of shelter living. Some, in desperation, place their children in foster care. Other children cannot return from foster care because their parents are homeless.

**The District has failed to invest in cost-effective services to prevent homelessness among families, to provide comprehensive services that help homeless families return to stable and permanent housing, and to develop low-income housing.**

- The city has sheltered families in dilapidated, dirty, and crowded hotel rooms at a cost of about $3,000 per month per family, far more than it would cost to subsidize the family's rent in an apartment. Even the transitional housing programs the city is using increasingly as alternatives to hotels are more expensive than helping families find and maintain permanent housing.

- Bad management has plagued the Department of Public and Assisted Housing (DPAH) and exacerbated the short supply of low-income housing. In the past 15 years the District has failed to spend $47 million in federal funds that could have been used to renovate badly needed public housing units. The fact that more than one-quarter of all budgeted staff positions at DPAH are unfilled hinders the department's ability to do repairs and renovation in public housing units.

## Recommendations

### Increase access to low-income housing.

- The District must work in partnership with the federal government, nonprofit and for-profit developers, and banks to increase the city's low-income housing stock. This should be done through construction of additional low-income housing units, rehabilitation of vacant public housing units, and expansion and careful oversight of the Tenant Assistance Program to ensure that families in need receive appropriate assistance.

- The District should increase both staff and funding for housing assistance programs under the Department of Public and Assisted Housing. The city should use more efficiently all federal funds available for these purposes. In addition, more local funds should be collected and committed to housing programs. For example, commercial real estate taxes should be assessed and collected properly. Strong linkage requirements should be promoted and enforced so that developers of commercial and luxury real estate contribute either low-cost units or financing for low-income housing. Additional city support should be provided to nonprofit housing development groups for both renovation and construction of low-rent units.

### Expand homelessness prevention activities.

- The District should focus on homelessness prevention, mobilizing all possible sources of funding and programming to identify and assist families before they become homeless. AFDC Emergency Assistance and special needs program funds can be used to help families cover back rent and other emergency needs. Federal programs funded by the Stewart B. McKinney Homeless Assistance Act can support prevention activities as well as critical services to homeless families. Successful community efforts that assist low-income families at risk of becoming homeless should be expanded with both city and private funds.

- The District should post a prevention worker from the Office of Emergency Shelter and Support Services in landlord-tenant court, and should include information about available resources (such as Emergency Assistance) on all relevant materials, such as eviction notices.

- The District should help homeless families move back into permanent housing as quickly as possible. This will require the provision of social services, case management, housing search assistance, and other necessary supports to all families immediately after they become homeless. Whenever needed, homeless families should continue to have access to support services once they are reestablished in permanent housing. High-quality, comprehensive, transitional programs should be available as an alternative for families that need special assistance to live independently.

**Improve the shelter system.**

- By July 1992 the city should stop using hotels to shelter families. The city should implement immediately the provisions of the Emergency Shelter Services Reform Act and comply with injunctions now pending that require: the provision of apartment-style shelter to all families after a maximum of 15 days in hotels, the dispersal of shelters in communities around the city, and the provision of services to help families reestablish self-sufficiency.
- In addition to complying with these mandates, the city should enforce basic health and safety standards for shelters so that families and children are not endangered during their stays there, and improve coordination between city agencies to help families return to permanent housing, to help families get access to all necessary services, and to ensure that homeless children are able to continue attending and achieving in the school of their choice.

## Vulnerable Children and Adolescents

### Findings

**Growing child poverty, increasing numbers of births to unmarried teens, increasing numbers of homeless families with children, and the crack cocaine epidemic have pushed many District children and families into crises.**

- In FY 1990 an average of 25 children a day were reported abused and neglected. More than 90 percent of these were reports of child neglect – children left unattended or without adequate shelter and supports. In the past five years the number of children involved in neglect reports has increased by almost one-third.
- Between FY 1985 and FY 1989 the number of children entering foster care increased by 31 percent. The number of very young

children entering care has increased significantly. More than half of the children entering care in January through March 1991 were younger than three.

- An estimated 6,800 District children have serious emotional problems or are at risk of developing serious emotional problems. Some problems have biological origins; others result from histories of parental neglect or abuse or maltreatment at the hands of the system.
- In FY 1989, 2,808 youths were arrested and had their cases petitioned for delinquent acts in D.C. Superior Court. Many of these youths were abused or neglected when they were younger, had special educational and mental health needs that never were met, or came from families plagued with financial, mental health, or substance abuse problems.
- Many of these children and their families, regardless of their labels, have similar multiple needs. They also face similar barriers to receiving necessary help.

**Preventive and early intervention services for children and families are severely limited. Too frequently families with problems have no place to go before crises intensify, and children end up placed away from their families.**

- In FY 1990 the Department of Human Services spent almost $36 million to support children in foster family homes, group homes, and residential treatment centers, but very little was spent on in-home crisis intervention and family preservation services.
- There is a serious lack of appropriate programs to address the multiple needs of families with substance abuse problems, and early intervention and day treatment programs for children with emotional problems are in short supply.
- Youths who end up in the juvenile justice system often have been denied preventive and early intervention efforts, and have been victims of early school failure. Twenty-one percent of the juveniles arrested in the city in 1990 were not attending school.

**Many District children who do not get the help they need are placed in often inappropriate and overly restrictive settings.**

- Foster parents are diminishing in numbers and often are not compensated or supported adequately to help the children in their care.

  - In 1989 about 800 children entered care, but in the three previous years only 70 foster homes were opened in the city. Severe overcrowding puts children at risk of harm.

  - Inadequate reimbursement rates, lack of funding for recruitment, and inadequate support services for those caring for children with increasingly specialized needs all hamper recruitment of foster homes.

  - The city operates few therapeutic foster family homes, although at least half of the children in foster care have special physical, mental, or emotional needs, and foster homes are more cost-effective than hospitals or residential facilities.

- As of July 1990 more than 250 children with emotional problems were placed in out-of-state residential treatment centers at an average cost of $80,000 per child per episode.

- Institutional care harms many District youths. The District's rate of institutionalization for youths is several times higher than that of any state.

  - The number of incarcerated youths nearly doubled between 1987 and 1990, despite a court order in *Jerry M. v. District of Columbia* requiring decreased reliance on institutions and despite a study showing that more than half of the committed incarcerated youths in the District were appropriate for community-based placements.

  - The cost of housing one youth at Oak Hill juvenile detention center is $40,000 a year, more than three times the cost of providing nonresidential vocational training and counseling programs, and six times the cost of programs like the underfunded High Intensity Supervision Program (HITS) operated by the D.C. Superior Court Social Services Division.

**There has been a lack of collaboration among the multiple agencies in the city charged with meeting the needs of vulnerable children and adolescents.**

- Little coordination and few joint efforts exist to address the myriad problems related to substance abuse, family homelessness, and inadequate housing.

- Expanded efforts are needed between child-serving agencies and the courts to ensure cases are processed in a timely fashion and appropriate dispositions are made.

- There has not been the leadership or commitment necessary to make permanent the interagency initiatives that do exist.

**Chronic staff shortages and inadequate staff supports have plagued the Department of Human Services. Recruitment and retention problems jeopardize the quality of care and services provided to children and families.**

- While abuse and neglect reports increased 28 percent between 1984 and 1988, during that time the Child and Family Services Division (CFSD) had a net increase of only two workers. Caseloads at CFSD have been as high as 251 children per worker -- and on average jeopardize, by CFSD's own admission, the division's ability to provide "even a minimum level of services and care to neglected and abused children and their families."

- Supervisors often must carry caseloads themselves. Outside supports are lacking and staff members also lack ongoing training, although much of the cost of training is partially reimbursable by the federal government.

- Staff shortages also have hampered the Youth Service Administration's progress in complying with the *Jerry M.* court decrees. They impair the level of supervision and programming that can be provided, and result in excessive use of overtime.

**District officials have failed to take adequate steps to strengthen these systems of care, despite the fact that detailed plans for reform in all three exist.**

- Reform has been hampered by indiscriminate hiring and spending freezes, contracting problems, inadequate budgeting, and reprogramming of funds.

- The District has failed to maximize federal funding available for care and services under the federal Foster Care and Independent Living programs, Medicaid, and the Supplemental Security Income Program. An estimated $14 million a year in federal funds could be claimed under the federal Foster Care Program alone.

## Recommendations

**Implement prior plans for comprehensive services and reform of fragmented systems.**

- The mayor must make an immediate commitment to expand interagency initiatives, increase community support, and strengthen the comprehensive systems of care needed in the city. As part of such a commitment, the mayor must designate a person responsible for developing a workplan, including a timetable, for fully implementing, within the next three years, all of the reform proposals included in the Final Order in *LaShawn v. Dixon*, the 1986 Mental Health Implementation Plan, and the Consent Decree and Memorandum Order B in *Jerry M. v. District of Columbia*. The mayor's FY 1993 budget should reflect the funding increases and redirections necessary to finance the first year of the implementation effort.

**Fully claim federal funds.**

- The Director of the Department of Human Services immediately should take steps to ensure that the department is using all federal funds to which it is entitled under Medicaid; the Title IV-E Foster Care, Adoption Assistance, and Independent Living programs; and the Supplemental Security Income Program, as well as other federal programs. It is critical that federal dollars received and any dollars ultimately saved through the avoidance of out-of-home care be reinvested in prevention, early intervention, family preservation, and community-based programs.

**Fill staff vacancies.**

- Representatives from higher education, the business community, public and private service providers, line staff, children's advocates, and religious leaders, as well as national experts, should be convened to begin filling the staff vacancies throughout the child welfare, mental health, and juvenile justice systems. Little will improve unless vacant positions are filled. Salaries and conditions for employment must be equivalent to those in neighboring jurisdictions. Enhanced pre-service and in-service training must be provided.

**Invest in prevention.**

- A family preservation service unit should be established to act as a gatekeeper for children at risk of placement in the child welfare, mental health, and juvenile justice systems. The experience of other cities can be drawn upon in developing an intensive family-based crisis intervention program that can accept referrals from all three systems. The community-based services necessary to supplement the intensive family-based services also must be established. Family preservation programs are not only beneficial to families and young people but are cost-effective, as well.

**Expand quality out-of-home care settings.**

- The District should expand the pool of quality out-of-home care settings available to children in the city. The regulations developed by the 1987 Mayor's Advisory Task Force to Develop Licensure Standards for Youth Residential Facilities to ensure basic protections and quality programming in residential placements should be published immediately for public comment and finalized.

- Public and private agencies should join to develop a network of therapeutic foster family homes that are compensated and supported adequately to meet the special physical and emotional needs of children whose families cannot be preserved. Private agencies should play a major role in the design of the network and in the recruitment, selection, training, and support of the foster parents. Broad community support is needed to enable the placement of therapeutic community-based programs throughout the city.

**Develop neighborhood-based services.**

- The District should develop cross-system, neighborhood-based initiatives that addresses the multiple needs of children and families involved or at risk of involvement in the child welfare, mental health, and juvenile justice systems. Private providers, religious organizations, civic associations, and other community groups should be enlisted to help in the design and delivery of services that help prevent children and youths from entering out-of-home care, work with families if placement is necessary, and provide support for families after children return.

## Family Income

### Findings

**Children are the District's poorest residents.**

- Nearly one in three children in the District is poor. While children make up only one-fifth of the total city population, they accounted for one-third of all poor District residents in 1986. Despite the fact that the District's median income -- $38,562 for a family of four in FY 1991 -- was higher than those of four-fifths of all states, the District's child poverty rate is 40 percent higher than the national average.

- Children in the District are poor because of low earnings among parents, because many live in single-parent households, and because the District's safety net for poor families is inadequate.

- Many District residents work in jobs that are part time, part year, or pay so little that they cannot lift themselves and their families out of poverty. Nearly half of poor working-age adults have jobs.

- Fifty-eight percent of District children live in single-parent (and in most cases female-headed) families, more than double the 1980 national average of 23 percent. About half of all children living in female-headed families are poor.

**More than 21,000 families, including more than 40,000 children, were receiving help from the Aid to Families with Dependent Children (AFDC) program in July 1991, yet the program fails to meet the income needs of many poor families.**

- The District's AFDC program pays only $409 per month to meet most of the needs of a three-person family. This amount is only about half the federal poverty level and less than two-thirds of the fair market rental value of a modest two-bedroom apartment in the District ($731).

- From 1970 to 1990 the value of the three-person AFDC grant fell by 36 percent in constant dollars. Recent action to repeal the automatic cost of living adjustment in AFDC further erodes already inadequate benefits.

- Even the combination of food stamps and AFDC benefits in the District does not lift children out of poverty. The combined value of the maximum AFDC grant for a family of three and food stamp benefits ($633 per month) is only 72 percent of 1990 federal poverty guidelines.

**While the projected AFDC caseload for FY 1992 suggests an increase over the FY 1991 caseload, staff shortages in the District's Income Maintenance office thwart the delivery of effective services to poor families.**

- With more than 150 vacancies in the Income Maintenance Administration, it is difficult for workers to comply with federal case processing timelines and nearly impossible to provide the individualized attention needed by many families that apply for AFDC.

- Many needy families are not helped by the food stamp program. The lack of staff trained to do outreach has contributed to a 19 percent decline from 1985 to 1989 in the number of persons benefiting from the food stamp program. This is particularly appalling since the federal government pays the entire cost of food stamps.

**The District does not use the AFDC program to provide preventive and cost-effective services to families, even though the city could receive federal matching funds to help it do so.**

- Nearly half of all AFDC families live doubled up or tripled up, yet the District has failed to use special needs grants under AFDC to ensure that poor families do not become homeless.

- The District has not provided AFDC parents with many financial incentives to work. For the fiscal year ending September 1988, only 2.9 percent of District AFDC households had earned income (compared with 8.4 percent nationally).

- The District fails to take full advantage of the Family Support Act to build creative programs that help teen parents stay in school or return to school if they have dropped out.

**Although the District's child support enforcement program potentially could provide increased income for families and revenue for the city, a lack of adequate funding and staff have made the Office of Paternity and Child Support Enforcement (OPCSE) unable to cope with the large demand for services.**

- In FY 1988, the last year for which national data are available, the District ranked second to last among states in the percentage of its average annual child support enforcement caseload for which a collection was made on an obligation. It also ranked thirty-fourth in the percentage of collections received.

- As of 1987 paternities were established for only 168 out of every 1,000 children born out of wedlock in the District -- far below the national rate of 273 paternities per 1,000.

- In recent years the District's child support enforcement efforts have improved significantly, but recent budget cuts now threaten these gains. New legislation that allows the program to keep federal incentive payments will help, but will not replace the need for funding increases for program enhancements and special efforts to process the backlog of tens of thousands of cases.

## Recommendations

### Provide greater job and training opportunities.

- To ensure that the District's poor families and children can benefit from the city's comparative affluence, the District government must join with major local employers, including the federal government, to improve access of local workers to stable employment. Such a partnership must work to improve the employment prospects of young workers by providing quality education city-wide, skills training, apprenticeship programs, adult education programs, English as a Second Language classes, and affordable child care, and by assuring that employment practices guarantee equal opportunity and equal treatment.

- Because many of the District's children are poor even though a parent works, we must boost parents' earnings through public and private action. Employers should make sure that wage levels are adequate to support a family, that eligible workers get advance payments of the federal Earned Income Credit to supplement their wages, and that employees and their dependents have employer-provided health insurance.

### Increase assistance for working families.

- The District can encourage families receiving AFDC to work by allowing families to keep more of their earned income without having their grants reduced. Given the importance of encouraging youths to take full advantage of education, training, and employment programs, the District also should take full advantage of AFDC options to provide incentives to youths who are trying to build their skills by allowing them to keep earnings or stipends while enrolled in such programs. The District also should consider using Family Support Act and other funding to create a comprehensive system of supports, including appropriate child care, for AFDC teen parents struggling to finish high school or obtain a GED.

### Enhance child support enforcement.

- A recently completed Office of Paternity and Child Support Enforcement (OPCSE) resource allocation plan estimated that OPCSE, the Office of Corporation Counsel, and the Superior Court need an additional 108 full-time positions to manage the child support caseload adequately. In addition, the plan recommends a temporary project to clear up 10,000 cases now awaiting paternity establishment services. The city should move swiftly to fulfill these objectives.

**Help AFDC families afford housing.**

- District families on AFDC face staggering barriers to finding affordable housing. The District should provide an AFDC special needs rent supplement to recipients whose housing costs are greater than 30 percent of the grant. A one-time revision of the standard of need and the grant level to adjust for increased housing costs, coupled with retention of annual cost of living adjustments, also would help families get sufficient income to remain housed. The District also should provide other housing-related assistance (such as necessary security deposits) through special needs grants to bring in additional federal matching funds.

- The District should institute presumptive eligibility for families that are clearly eligible for AFDC and need the assistance to remain housed, or to leave the shelter system. For some families, prompt AFDC assistance may help avert or resolve a housing crisis. While 17 states process an AFDC application within 30 days, the District of Columbia takes 45 days -- a lengthy process for families in need. Fourteen states provide AFDC assistance prior to a complete determination of eligibility when the facts support a presumption of eligibility.

- The Emergency Assistance program should be expanded to obtain federal matching funds for housing-related services for needy families. The District uses the Emergency Assistance program to provide some housing-related services to poor families (including poor families that do not receive AFDC). However, the District does not use this program to provide services that other localities or states have found effective in helping families find housing once they have become homeless -- for example, housing search workers who work with homeless families and potential landlords, and child care for homeless children so a parent can search for housing and employment.

**Address shortfalls in staffing.**

- The city should hire more caseworkers and supervisors to determine family eligibility for assistance and to respond better to families' needs when they are in crisis. Hiring freezes that result in a system too overloaded to respond quickly are not in the best interests of families.

**Restore cuts in public assistance.**

- The City Council and Congress should restore the reductions in public assistance made as part of the FY 1992 budget. Children and families will be hurt further if the FY 1992 proposals to reduce benefits in the AFDC program by 4.5 percent and to suspend the annual cost of living increase in AFDC are allowed to stand. It is also unacceptable to reduce General Public Assistance benefits for adults with physical and mental disabilities in order to meet the costs of providing AFDC to increasing numbers of needy families with children.

- Steps should be taken to ensure that federal penalties assessed against the District's AFDC funds because of past child support enforcement inadequacies do not harm AFDC children.

**Strengthen food stamp outreach.**

- Reinstate the position of outreach coordinator and target funds for outreach to potentially eligible families. Such outreach may be done effectively through contracts with community-based groups that work with low-income families.

- Exempt food stamps from the current freeze to allow the hiring of enough workers to serve food stamp applicants promptly and properly and to identify cases entitled to expedited emergency processing.

- Provide ongoing training to workers to ensure that they understand food stamp procedures and are capable of properly counseling families about their rights and responsibilities.

## Management and Budget Practices

### Findings

**Many of the severe shortages in services for children and families in the District are in part the result of ineffective program management. The District often defunds or fails to implement cost-effective programs, fails to maximize federal funding, and fails to spend appropriated funds.**

- The amount the city budgets each year for children's programs often bears little resemblance to what is spent. Some programs spend far more than their appropriated budget when the need exceeds what originally was anticipated. Others do not spend all their funds because of across-the-board freezes or administrative delays in contracting for services, purchasing equipment, or hiring staff.

- Spending and revenue estimates set by the Mayor's Budget Office are often unrealistic and shortfalls are created. The city government does not plan accurately for increased demands for services, overestimates federal revenues, and fails to budget adequately for administrative costs, such as rent and utilities.

- Across-the-board freezes on hiring personnel have failed to distinguish between inefficient and efficient programs, between programs that generate revenue and those that do not, between federally funded programs and those funded with local dollars. Such freezes do not exempt service agencies with severe staff shortages. These freezes not only hurt children and families, but often fail to achieve the desired cost savings.

- Administrative barriers also frustrate attempts to spend appropriated funds. The centralization of many of the "tools" needed to implement programs (such as the acquisition of supplies, equipment, and contracts) delays the start-up of new programs and hinders improvements in existing programs. There is little incentive for innovation and creative administration.

- Budgets for health, foster care, mental health, and juvenile justice are developed and implemented separately, even though the programs often serve many of the same children and families. The failure to coordinate leads to fragmentation, needless duplication, and inefficient use of available funds.

- The District does not take full advantage of available federal funds.

    - The District claims federal financial assistance on less than 25 percent of the children in foster care, although it is estimated that about 60 percent may be eligible.

    - Over the past decade $47 million in federal funds for rehabilitating low-income housing went unspent.

    - The District failed to submit all of its federal claims for emergency assistance payments to the homeless, losing more than $4 million between 1985 and 1989.

    - Public health clinic staff often do not bill Medicaid for services provided to Medicaid-covered patients, resulting in the city's losing millions in federal matching funds.

- The District has failed to capture federal funds because of staffing shortages in key areas, lack of standard operating and recordkeeping procedures, failure to train staff to understand reimbursement policies and procedures, and inadequate management information systems.

- Even when the District successfully captures federal grant dollars, it cannot always spend them to benefit children. City spending freezes affect both local and federal funds. In addition, often when federal funds are received they cannot be "kept" by the programs to expand their services, but instead are reverted to the general fund.

**Much of what the District actually spends on children is for high-cost, restrictive, and often inappropriate programs such as juvenile detention centers, residential treatment facilities, long-term foster care, and "welfare hotels," rather than more humane and cost-effective prevention, early intervention, and diversion programs.**

- While about $25 million a year is spent on residential treatment facilities, very little is spent on less restrictive and less costly community-based therapeutic foster homes, group homes, and respite care services.
- While about $14 million is spent by the child welfare agency to support children in foster family homes and group homes, very little is spent on in-home crisis intervention and family support services to prevent removal of children from their families.
- While millions of dollars are spent to provide intensive care to the hundreds of infants born too sick or too small, insufficient investments are made to provide pregnant women with access to quality health care that can help prevent low-birthweight births.
- While almost $21 million is spent on juvenile detention centers, only about half that amount is spent on community-based alternatives to detention.
- While an average of $3,000 per family per month is spent to house more than 200 homeless families in hotels, many would require less than $500 a month in housing assistance to retain permanent housing.

## Recommendations

**Improve budget development and implementation.**

- Develop spending assumptions in close consultation with program managers so that they accurately reflect anticipated growth in the number of children and families needing services. Similarly, program managers need timely and accurate information about administrative and overhead cost increases.

- Reject indiscriminate across-the-board freezes in contracting for services, purchasing equipment, or hiring staff as a budget control device. Decisions about cost containment measures should exempt direct service programs that already suffer from severe staff shortages and cannot limit their services, programs that generate revenues for the city, and programs that are of proven cost-effectiveness.

- Address deficits in personnel spending by changing the existing D.C. Personnel Act and the federal personnel regulations to allow for targeted reductions in force or in grade where there is excess, and redistribution (and necessary retraining) of staff where there are shortages. In areas that have unacceptably high client-to-staff ratios, as in child welfare, new hires must be allowed.

**Improve program management.**

- Coordinate program initiatives across child-serving agencies, maximize resources, and develop comprehensive services for children and families with multiple needs. Investments in community-based therapeutic settings, in-home services, substance abuse treatment, and case management can be made using Medicaid, foster care, education, and juvenile justice dollars.

- Child-serving agencies should work together to develop budget initiatives and management information systems that will enhance efforts at interagency coordination.

- Program managers should have greater control over their budgets and spending. The city should institute a system of rewards that supports good managers.

**Maximize federal resources.**

- A cross-system effort should enhance federal revenues under Medicaid, the Title IV-E Foster Care and Adoption Assistance programs, the Supplemental Security Income Program, the Child Support Enforcement Program, and other federal programs. To facilitate appropriate claiming of federal funds, procedures must be implemented to ensure accurate eligibility determinations, full training of staff in relevant procedures, the institution of tracking systems, and programmatic improvements.

- Ensure that programs that generate expanded federal revenues reinvest funds that are received in expanded preventive and community-based services rather than having the money revert to the general fund.

- Revise the city's central Financial Management System so that federal and foundation grant monies can be accessed and spent more efficiently. Grants currently in the system should be exempt from any imposed spending freezes.

# Maternal and Child Health

In the District of Columbia, capital of the richest and most powerful nation on earth, child health conditions rival those in less developed nations. Whether measured against other states or big cities, the District's infant mortality and low-birthweight rates are the country's highest; its prenatal care and early childhood immunization rates are among the nation's worst. The city also ranks poorly on indicators such as the incidence of AIDS among women and children and mortality rates from natural causes among preschool children. And despite all that is known about improving child health and the cost-effectiveness of maternal and child health services, thousands of women, infants, and children go without basic care. Children are at grave risk for poor health in the District because of endemic poverty, a lack of health insurance, and limited access to affordable health care.

Failing to ensure health care for the city's children is exacting a high human and financial toll. Every time a low-birthweight infant is born to a woman who did not receive prenatal care, the city pays twice: once for the human tragedy of a baby born small enough to hold in one's hand, and again for the financial catastrophe that comes from the neonatal intensive care and aftercare needed to sustain so fragile a child. For every baby who dies in the District another 10 will be left with a lifetime of disability.

Particularly disturbing are the tremendous differences in health between the District's black and white children. The wide income disparities between the District's black and white citizens are reflected in the health of black and white mothers and children. By most measures, white mothers and babies in the District enjoy good health. Yet the health status of black mothers and children in the District is among the worst in the nation – compared not only with white mothers and children but with black mothers and children in other cities and states.

## Infant Health: A National Disgrace

### Infant Mortality

The city's record on infant mortality is especially shameful. A child's chance of survival until his or her first birthday is a key indicator of a population's overall social, economic, and physical health status. Infant health reflects the economic, medical, and social supports mothers receive before pregnancy and the environment in which babies grow after birth. Access to proper nutrition, decent income, adequate housing, and a safe community is as critical to a baby's healthy birth and survival as medical care. Consequently, the District's high infant mortality rate reflects not only poor access to maternal and child health services, but also the impoverished and even unsafe conditions that so many Washington children and adolescents endure. Comparisons with other nations, states, and cities underscore the crisis faced by pregnant women and infants in the District.

- The District's 1988 overall infant mortality rate of 23.2 deaths per 1,000 live births was worse than all 50 states and more than twice the national rate of 10.0 infant deaths per 1,000 live births. An infant born in the District was less likely to survive one year than a baby born in Jamaica, Costa Rica, or Cuba.

- The 1988 black infant mortality rate was 26.0 deaths per 1,000 live births. The District placed worst among states and worst among the nation's largest cities with measurable black infant death rates. In 1988 a black infant born in the District was less likely to survive than an infant born in Malaysia or Yugoslavia.

### Low Birthweight

Too many infants born in our nation's capital enter the world too small. More than 14 percent of all District infants were born at low birthweight (less than 5.5 pounds) in 1988. These babies are 20 times more likely than normal weight babies to die within a year.

While improved medical technology can save many small newborns, it comes at tremendous cost. A typical hospital stay for a low-birthweight baby costs $20,000 to $100,000, compared with less than $5,000 for routine prenatal and delivery care. Moreover, low-birthweight babies who do survive suffer many more health problems than their normal weight counterparts. Developmental disabilities such as mental retardation, vision, hearing, and learning disabilities are linked to low birthweight.

## How the District Ranks

(1988)

### Among States

#### All Races

| | |
|---|---|
| Infant mortality | 51st |
| Low birthweight | 51st |
| Proportion of women receiving early prenatal care | 50th |

#### Black

| | |
|---|---|
| Infant mortality | 35th out of 35* |
| Low birthweight | 43rd out of 43* |
| Proportion of women receiving early prenatal care | 42nd out of 50* |

### Among Cities with Populations Greater than 500,000

#### All Races

| | |
|---|---|
| Infant mortality | 25th out of 25 |
| Percent of all births that are to teens | 15th out of 25 |
| Percent of all teen births that are to unmarried teens | 22nd out of 22* |

#### Black

| | |
|---|---|
| Infant mortality | 19th out of 19* |

* Among cities/states with measurable rates

Source: National Center for Health Statistics. Calculations by the Children's Defense Fund.

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## Inadequate Prenatal Care

Children born to women who receive insufficient prenatal care are significantly more likely to be born at low birthweight. In 1988 more than 11 percent of all infants born in the District were born to mothers who received late or no prenatal care -- almost twice the national average of 6.1 percent.

Early and continuous prenatal care can reduce low birthweight and save children's lives. Yet in 1988 only 61.2 percent of all District infants were born to women who received prenatal care in the first three months of pregnancy (compared with 75.9 percent nationally). Every $1 invested in prenatal care saves more than $3 in medical costs in the first year of life alone by averting low birthweight. Long-term savings in medical, special education, and social service expenditures bring total savings to as much as $9 for every dollar spent. Prenatal care can detect a variety of conditions that place mother and baby at risk. The health education and other social supports that are part of comprehensive prenatal and maternity care are important to preparing a mother for pregnancy, childbirth, and parenting. Many serious complications of pregnancy can be treated if identified early -- within the first three months of pregnancy.

The adequacy of prenatal care is measured both in terms of the timing of entry into prenatal care and the number of visits. A woman who has one prenatal care visit early in pregnancy but does not continue with regular visits may face the same risk as a woman who receives only one visit the month prior to delivery. Adequate prenatal care begins in the first three months and includes at least nine visits for a normal length pregnancy. Care is deemed inadequate if a woman has fewer than four prenatal visits or does not enter care before the seventh month of pregnancy.

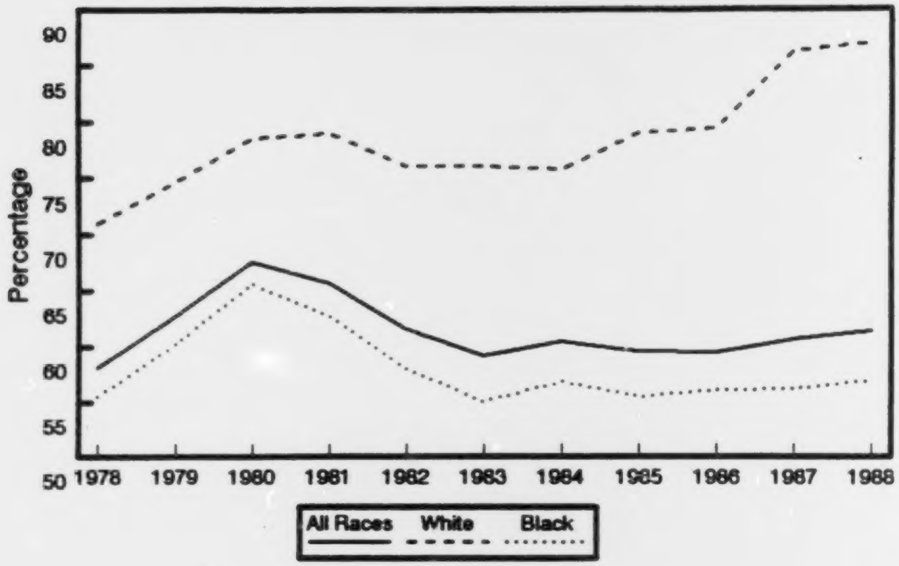
Only half (51.3 percent) of all 1988 births in the District were to women who began care early and had enough prenatal care visits. Just 46.0 percent of black infants in the District were born to mothers who received adequate prenatal care in 1988. In contrast, 81.3 percent of the city's white infants were born to mothers who received adequate prenatal care.

## Births to Teens

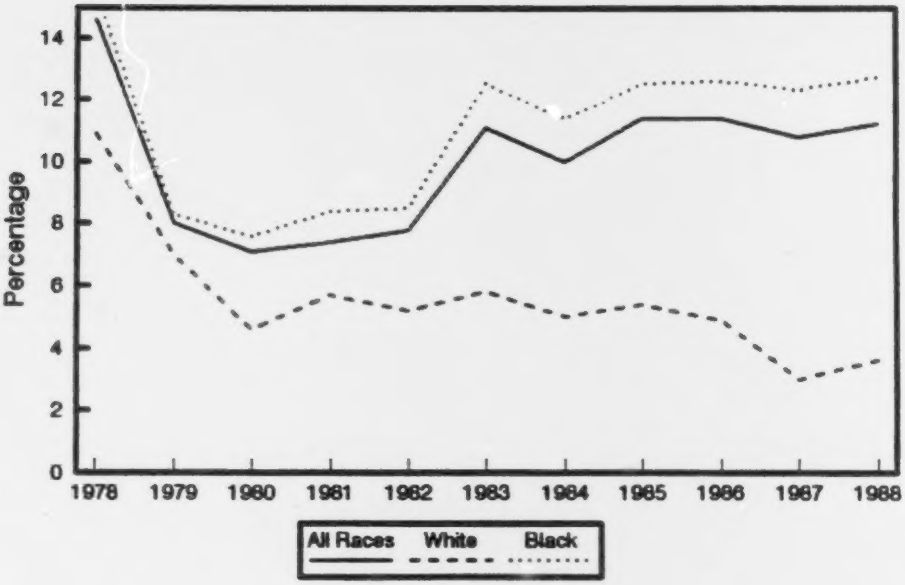
While only the youngest teenagers (girls younger than 15) have biological risks for childbearing, teenage childbearing has enormous health, social, and economic consequences for both mothers and infants. In 1988, 1,854 infants were born to District teens, including 80 births to

*(continued on page 55)*

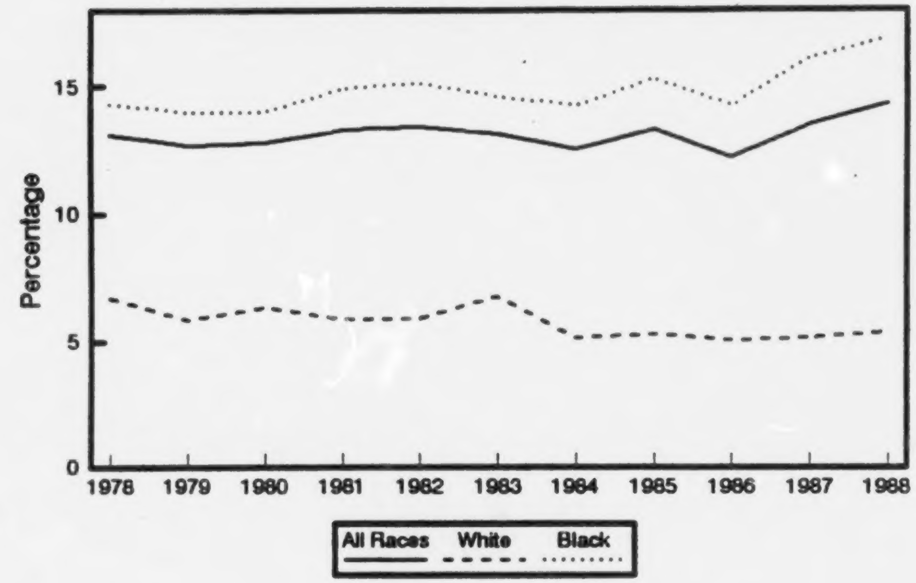
## Percentage of Infants Born to Mothers Receiving Early Prenatal Care, D.C.,1978-1988



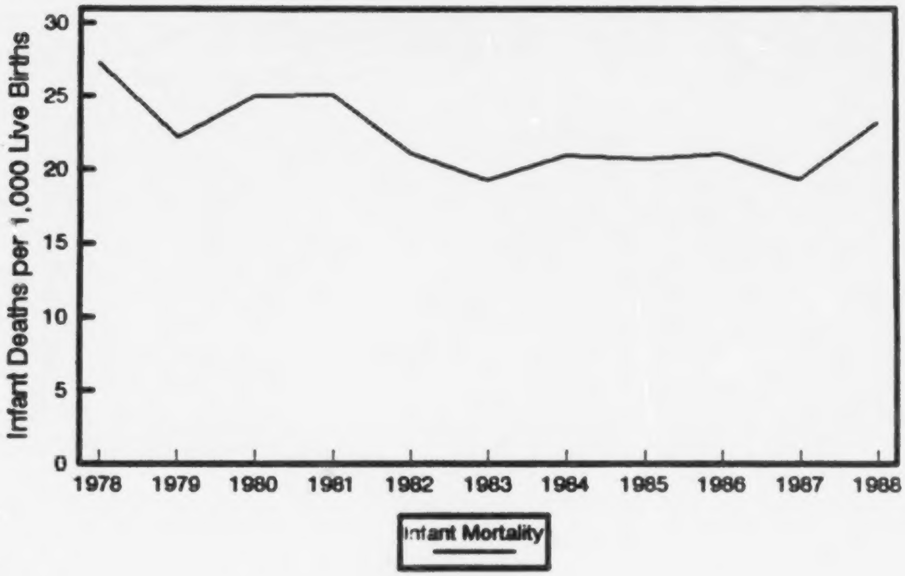
## Percentage of Infants Born to Mothers Receiving Late or No Prenatal Care, D.C., 1978-1988



Percentage of Infants Born at Low Birthweight, D.C., 1978-1988



Infant Mortality Rate, All Races, District of Columbia, 1978-88



girls younger than 15. One in six District infants was born to a mother younger than 20 that year. Of all births to teens, fewer than half (46.5 percent) were to teens who received early prenatal care; 16.4 percent had no prenatal care or none until the last three months of pregnancy.

Unmarried teen mothers are at greater risk of poverty and a lack of social supports. In 1988 nearly 94.7 percent of all District births to teens were to unmarried women; 96.6 percent of black births to teens were to unmarried women, compared with 68.9 percent of their white counterparts.

### Trends in Maternal and Infant Health

District health officials indicate that the city's infant mortality rate remained high in 1989 and 1990. The Centers for Disease Control (CDC) reported in 1990 that the District's infant mortality rate has been *rising* by 1.6 percent a year since 1984 -- a situation unparalleled anywhere else in the nation. The worsening rate follows a period of dramatic improvement (between 1978 and 1983), when the District's infant mortality rate dropped by an average of 5.7 percent a year. This rapid reduction in infant mortality was one-and-a-half times the national average rate of improvement during that time period, according to the CDC.

The CDC attributed the District's improvements in the early 1980s to implementation of recommendations included in the 1980 final report of the Mayor's Blue Ribbon Committee on Infant Mortality. Those recommendations centered on improving hospital care and implementing technological advances in intensive care treatment to save more low-birthweight babies. During that period prenatal care use also improved. The proportion of women who received late or no prenatal care dropped from 15 percent in 1978 to 8 percent or less during the 1979 to 1982 period.

However, advances in medical technology alone cannot save babies. The sheer number of low-birthweight and at-risk births in the District each year is driving death rates upward. By the mid-1980s technological improvements were outpaced by the deteriorating health status of women of childbearing age and their worsening access to prenatal care. In turn, low-birthweight and infant mortality rates increased and gains during the early 1980s evaporated.

### *Drugs*

The epidemic of drug use among women of childbearing age that struck the District during the late 1980s affected its most vulnerable citizens. Few programs are available to provide prenatal care and substance abuse treatment to pregnant women. Although local and national data are not comprehensive, anecdotal reports suggest that substance abuse among pregnant women increases the incidence of low birthweight, prematurity, and birth complications, all of which are leading factors underlying infant mortality.

According to officials at D.C. General Hospital, the city's only public hospital, 22 percent of the babies delivered in 1990 were drug-exposed. At Greater Southeast Community Hospital 40 percent of the babies delivered were drug-exposed.

### *Acquired Immunodeficiency Syndrome*

As drug use among childbearing women grows, the incidence of infection with the AIDS-causing HIV virus also increases. HIV infection increasingly is becoming a disease afflicting poor and minority urban residents. A recent CDC report found that in 1990 one in 74 births in the city (more than 1 percent of all births) was to a woman infected with the HIV virus, and that the city had emerged as one of the nation's AIDS epicenters for women and children. In the District 89 percent of those with pediatric AIDS (children younger than 13) are black. As of December 1990, 35 cases of pediatric AIDS have been reported in the District, up from 28 cases the previous year. D.C. General Hospital officials estimate that in 1991 six babies at the hospital will be diagnosed with AIDS before their first birthday, and 25 more will develop AIDS later in childhood.

## Child Health: A Less Visible Tragedy

While children usually are most vulnerable to death during their first year of life, their health care needs are no less important after infancy. Though infants are more likely to succumb to threatening conditions than older children, barriers to health care continue long after a child's first birthday. And like prenatal care for pregnant women, if health services are not provided to all of the District's children, the city inevitably will pay a high human and economic toll.

## Childhood Mortality

While death is much less common among children who survive infancy, child mortality rates in the nation's capital show that children here face a significantly greater risk of death than their peers nationwide. For the District's preschool children (ages one to four) the average 1981 to 1985 mortality rate of 73.5 deaths per 100,000 population was one-third higher than the national average of 55.3. (The years 1981-1985 were grouped together because the rate from any single year would have

### The Health of the District's Children

- The city's 1981-1985 mortality rates from natural causes among children ages one to four and 10 to 14 were the highest in the nation. Its 1981-1985 mortality rate from natural causes for children ages five to nine ranked the city forty-eighth in the nation.
- Children from the city's poorest neighborhoods are hospitalized for preventable illnesses at two to three times the average Washington, D.C., metropolitan rate.
- Only 43.2 percent of all District two-year-olds are immunized against preventable childhood disease, compared with an already shockingly low national rate of between 70 and 80 percent.
- In 1989 drugs were implicated in 949 emergency room admissions of children ages six to 17, compared with 756 in 1988. The Commission of Public Health estimates that 22 percent of the addicted and abusing population is younger than 19.
- Between 1987 and 1989 the number of syphilis cases among women ages 10 to 24 increased 173 percent.

been statistically unreliable.) Only two states had higher mortality rates among children this age. For older children, the District's death rates also were very high. The 1981-1985 mortality rate among District children ages five to nine -- 32.8 deaths per 100,000 -- was higher than in 43 states and 23 percent higher than the national average. The city ranked thirty-ninth among states in the mortality rate of children ages 10 to 14.

Deaths from natural causes were particularly high in the District. These deaths include both essentially nonpreventable causes of death, such as cancer and birth defects, and preventable causes such as pneumonia, meningitis, and HIV infection (AIDS). From 1981 to 1985, among all states, the District had the highest rate of deaths due to natural causes for children ages one to four and for children ages 10 to 14. It is tragic that childhood deaths remain high despite the reductions possible through better living standards and access to health care.

Deaths from natural causes, for example, often can be prevented if children receive sufficient and timely health monitoring and treatment. Pneumonia, a common cause of death among young children, is relatively simple to detect and treat. However, delaying care for only a few days or even hours can mean life or death to a toddler suffering from pneumonia.

## Untreated Illnesses

Child health problems associated with poverty and deprivation are well-documented. Not only do poor children suffer higher rates of mortality, but they are significantly more likely than nonpoor children to be limited in their major life activities because of chronic illnesses or disabilities. And when illnesses and disabilities do strike, poor children suffer more severely.

Disparities between the health status of lower and higher income children show up starkly among District children. A 1988 study conducted for the D.C. Hospital Association found that children in the city's poorer neighborhoods suffered alarmingly high rates of hospitalizations for illnesses that could have been prevented or ameliorated through timely health care. Anacostia, Benning Heights, Trinidad/Ivy City, and other low-income District neighborhoods all experienced extremely high rates of hospital admissions for children for bronchitis and pneumonia. A $3,000 hospital stay for a child with severe chronic asthma could be averted by weekly office visits for a cost of $1,000 a year.

### Low Immunization Rates

One of the most disheartening trends in child health is the reemergence of preventable childhood diseases because of falling immunization coverage. Immunizations are one of the most cost-effective forms of health care. Each dollar spent to vaccinate a child against preventable diseases saves between $10 and $14. These statistics on cost-effectiveness and preventive health make District immunization statistics particularly shocking.

The District health department reported in February 1991 that only 43.2 percent of all two-year-olds in the District were fully immunized against childhood disease. The national average, according to the U.S. Public Health Service, is between 70 and 80 percent. Infant immunization rates in the nation's capital are no better than in Haiti, the poorest nation in the Western Hemisphere.

Washington's poor immunization coverage is due to high vaccine costs and overburdened public clinics. Over the past decade, vaccine prices have skyrocketed. Not only have vaccines become unaffordable to the poor, but many middle-class families also are affected because most private insurance plans do not cover the cost of immunizations. Studies have shown that many private pediatricians have changed their immunization practices because of affordability concerns. More and more doctors are telling their patients to go to a public clinic for immunizations rather than providing the immunization when the child is in their office. The result is a "missed opportunity" to protect the child from disease.

Furthermore, the influx of additional patients to the public immunization programs has overwhelmed an already overburdened clinic system. Consequently, there are too few staff persons, and occasionally too little vaccine, to serve the families that seek immunizations in the District's public clinics. Not surprisingly, more children simply have gone without protection against deadly childhood diseases.

### Special Risks to Teens

Drug use, violence, and sexually transmitted diseases pose a significant threat to the lives of teens in the nation's capital. Although drug use is a problem throughout society, poor communities suffer the most. In the city's poorest, most vulnerable neighborhoods, economic opportunities are limited and affordable treatment and recovery services are rare or nonexistent. With the increased availability of crack cocaine in recent years, the District has experienced major increases in drug-related emergency room admissions and overdose deaths, two of the most dramatic indicators of substance abuse.

Emergency room admissions involving drugs, according to official records, increased 300 percent between 1984 and 1988, from 4,213 in 1984 to 16,841 in 1988. While the total number of drug-related admissions fell in 1989, the number rose for children. Drugs were implicated in 958 cases among children ages six to 17 in 1989, up from 756 in 1988. The Commission of Public Health estimates that 22 percent of the addicted and abusing population is younger than 19.

Violence also threatens the District's teens. Nationally, male teens are more likely to die from gunshot wounds than from all natural causes combined. Between 1984 and 1988, firearm deaths in the United States among boys ages 15 to 19 increased 43 percent to nearly 18 deaths per 100,000 population, the highest level ever. For young black males the rate more than doubled between 1984 and 1988, to 79.5 deaths per 100,000. In 1989, 71 District teenagers between the ages of 15 and 19 were murdered. Homicide accounted for more than three-quarters of the total deaths in that age group.

AIDS and other sexually transmitted diseases are becoming increasing threats to teens in the District, although only five teens in the District have been diagnosed with AIDS. This is not surprising given that the lag time between HIV infection and AIDS diagnosis can be as long as 10 years. As of December 1990, 122 young adults ages 20 to 24 were diagnosed with AIDS. It is presumed that all of these individuals were infected as adolescents. Recent seroprevalence studies to determine the numbers of teens infected with HIV at Children's Hospital confirmed the belief that HIV infection is prevalent in teens. Many experts believe that female teens, who most often have older sexual partners, are more likely to contract HIV infection or other sexually transmitted diseases.

While HIV infection is certainly the most serious sexually transmitted disease, other diseases, specifically syphilis, have become increasingly prevalent among the District's teens. Between 1987 and 1989 the number of syphilis cases reported among young women ages 10 to 24 increased 173 percent, and the overall number of cases for both sexes more than doubled. The rising incidence of sexually transmitted disease dramatizes the risky behaviors in which too many teens and young adults engage.

## Thousands of District Children Are Uninsured and Underserved

No family can provide for its children's health needs without health insurance and without a place to go for health care. Although two-thirds of all poor families have an employed worker, they are far less likely to have private health insurance through employment and frequently live far from neighborhoods in which private physicians practice. Thus, they must rely on Medicaid coverage, publicly funded health clinics, and hospital outpatient departments for their health needs.

### Lack of Health Insurance Coverage

Erosion in the nation's employment-based health insurance system has left millions of poor and near-poor families without the means to pay for health care. Between 31 million and 37 million Americans – more than three-quarters of whom are workers or their dependents – lack health insurance. This national problem is mirrored in the District.

In 1987 one in six District residents (17 percent) had no health insurance. The District government estimates that there were about 100,000 residents with no health care coverage, either public or private, that year. Poor residents were twice as likely as nonpoor residents to be uninsured. In all, 27 percent of all poor residents and 17 percent of all children – nearly 25,000 in all – lacked health insurance. Poor children are more likely than poor adults to have Medicaid, and therefore generally are more likely to have some form of health insurance.

Large parts of Washington have so few health care providers that they are designated by the federal government as "medically underserved." As a result, families may be forced to delay or go without necessary care. Children miss preventive visits and immunizations. With no other choices, families often turn to inappropriate sources for routine care such as hospital emergency rooms.

### The City's Failure To Ensure Basic Care

Despite the cost-effectiveness of maternal and child health care, and the human and financial consequences of not ensuring it, the District has failed to respond to this urgent need. Even as D.C. General Hospital is pressed to the point of collapse and the city's private hospitals are overwhelmed by uninsured patients, the city has not mounted a comprehensive health initiative. Instead, the strain on the District's health care system has been exacerbated by a failure to maximize Medicaid revenues and cutbacks in the public health clinics.

#### *Medicaid*

In the District, as elsewhere, Medicaid is the primary source of health care funding for low-income children and their families. Although Medicaid is the largest public health program, it is not well coordinated with other health programs. Medicaid is a joint federal and state health financing program that operates much like private insurance by furnishing coverage to eligible individuals and paying providers of health care for services furnished. Each state administers the program within the scope of broad federal guidelines. The federal government contributes 50 percent of the cost of administering the D.C. Medicaid program. In essence, for every dollar the District provides in local Medicaid funding, the federal government contributes another dollar. Thus, Medicaid frequently offers the most economical means for supporting the small, critical number of health clinics and providers who serve the poor.

In FY 1988 more than 46,000 children in the District received health services paid for by Medicaid. Recent expansions of the Medicaid program require coverage of children up to age six with family incomes below 133 percent of the federal poverty level ($14,816 per year for a family of three) and all children ages six through 18 born after September 30, 1983, with family incomes below the federal poverty level ($11,140 per year for a family of three). In addition, the District covers pregnant women and infants with family incomes below 185 percent of the poverty level ($20,609 per year for a family of three).

***Complicated application procedures:*** Many eligible pregnant women and children never obtain Medicaid because of confusing and difficult application requirements and procedures. Studies in numerous states have found that as many as two-thirds of applicants are denied benefits not because they are ineligible but simply because they are unable to complete paperwork on schedule. Far too frequently the Medicaid program catches up with children – at great cost – only after they have been born too soon or too small or after they become critically ill or disabled.

When families need health care, they go to a doctor or clinic. Yet the District's Medicaid program requires families to go to a welfare office first, despite recent federal mandates to the contrary. Federal legislation enacted in 1990 requires states to accept Medicaid applications and make eligibility determinations for pregnant women and children at hospitals serving large numbers of poor patients and at community health centers. The practice, known as "outstationing" of eligibility workers, connects the Medicaid program directly to health services. The same procedures can be instituted in the neighborhood clinics to maximize Medicaid participation.

The legislation also requires state Medicaid programs to create shortened application forms for children and pregnant women who apply for Medicaid benefits at outstationing sites. The same shortened application then could be used at other facilities, such as the District's neighborhood clinics. However, the District has not yet created a shortened application form and District families must struggle with the current 10-page form. In contrast, several states have shortened their Medicaid application to just one or two pages. The sheer length of the current Medicaid application form is often enough to discourage a family from applying. Even families that are permitted to fill out a "presumptive eligibility" or preliminary application in the neighborhood clinics must go to a local welfare office and complete additional paperwork to file a formal application.

The barriers imposed by the Medicaid application process are particularly difficult for families with low-literacy or poor English skills, or no place to keep family records. Applications written in languages other than English and simplified procedures for verifying family income, children's birth dates, and pregnancy, status will help more families receive needed services.

***Application delays:*** Delays in the Medicaid application process are another barrier to care. It can take the District months to approve an application. In the case of a pregnant woman, such a wait is too long and almost certainly means prenatal care would be delayed. For example, if a woman confirms her pregnancy during the second month of pregnancy and applies for a Medicaid card immediately, she may not be able to use her coverage until her fourth month of pregnancy, long after she should have begun prenatal care.

Many states voluntarily have developed expedited enrollment programs for pregnant women. Presumptive eligibility, a special Medicaid option that allows pregnant women to be given temporary Medicaid coverage as of the date of application, has proven to be a highly effective means of assuring swift enrollment. The District began a presumptive eligibility program on July 1, 1991.

***Poor access:*** Insufficient administrative and operational resources for the Medicaid agency have cost thousands of children the valuable benefits they are entitled to under Medicaid. Too many children, for example, fail to benefit from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, which is the special child health component of Medicaid. EPSDT is designed to provide all children younger than 21 with comprehensive health examinations (known as screens) and immunizations, and treatment for conditions that are discovered by the screening process. Under EPSDT reforms enacted in 1989, states and the District must now ensure that all medically necessary care for children allowed under federal law will be available when an EPSDT exam discloses physical, mental health, or developmental problems.

In the District, however, the EPSDT program performs poorly. In 1989 the program provided just 21 screening exams for every 100 EPSDT-eligible children. For children younger than six, the District provided just 27 screens for every 100 children eligible, even though every child younger than six should have at least one exam per year and children younger than two need to be examined several times during the year. Steps must be taken to ensure that more children receive exams under EPSDT so their health needs can be identified and they can receive the medically necessary care required for conditions or problems that are disclosed during the exams.

The District must also continue its efforts to extend to more children the broader range of services under Medicaid and EPSDT. The 1989 EPSDT reforms also offer coverage for many specialized services provided to children through the city's special education, mental health, and child welfare systems. These agencies now serve thousands of Medicaid-eligible children and pay for benefits with local funds that could be reimbursed under Medicaid with federal matching funds. Additional outreach to these agencies is needed to ensure that eligible children get EPSDT exams and that services are provided that meet the needs identified.

***Too few Medicaid providers:*** Medicaid eligibility means little if no provider will furnish care once coverage has been secured. Like all states, the District has a severe shortage of Medicaid providers. Part of the problem is simple geography: there are too few physicians practicing in neighborhoods where large numbers of poor families live and transportation to neighborhoods where physicians can be found is difficult. Part of the problem is very low payment rates for services. For example, the District's Medicaid program reimburses physicians just $30 for an office visit, far lower than what privately insured or self-pay patients are billed.

A third cause of the shortage is the District's failure to use Medicaid and other funding to develop and staff comprehensive primary health clinics in underserved neighborhoods. As the Rivlin Commission (the Commission on Budget and Financial Priorities) found, clinics that do exist often provide too few services and are not open sufficient hours to serve patients adequately. In a city that is extraordinarily poor and whose low-income residents frequently are segregated into isolated neighborhoods, maintaining a comprehensive system of primary health services for uninsured and publicly insured residents is vital. Yet the District has failed to respond.

### *The District's faltering public health clinic system*

> *We're holding things together with bubble gum and Band-Aids. But you can't imagine how much worse things would be if we weren't here.*
>
> Dr. Georges Benjamin
> D.C. Commissioner of Public Health (1990)

The critical shortage of private physicians in poor neighborhoods and very low Medicaid participation among the city's private physicians mean that low-income residents are extraordinarily dependent on public clinics and hospitals. Yet the city's public clinic system is grossly inadequate.

When the temperature climbs in Washington's sweltering summers, the District of Columbia's neighborhood health clinics begin to close. The physical facilities of many of the city's public health clinics are so poor that staff has no choice but to close in extreme weather. On the hottest days, when open doors and electric fans cannot keep a room comfortable, city clinics without air conditioning simply shut down. Phones go unanswered, doors are locked, appointments are canceled, and patients go uncared for. It is not unheard of for staff to simply leave a note on the door saying the clinic is closed. During the winter, most clinics report that staff bring in space heaters to keep the examining rooms warm. At other times of the year peeling paint, crowded spaces, inadequate waiting areas, and understaffing erode the morale of staff and turn away all but the most desperate patients seeking health care.

The Commission of Public Health (CPH) operates 15 neighborhood health centers around the city, only 11 of which offer prenatal and pediatric health services. The clinics are designed to provide primary health care needs to all District residents regardless of ability to pay, with free services targeted to the population living below 200 percent of the poverty level.

The need for public health services is greater than ever before, yet over the past few years there has been a steady erosion in the allocation of resources. Consequently, facilities have deteriorated, staffing has become increasingly inadequate, and clinic hours have been shortened. The result has been a significant loss in the clinics' capacity to serve District residents.

Three years ago, CPH opened two of its most heavily used clinics two nights a week to serve working families. The evening hours at the

Benning Heights and Congress Heights clinics drew a flood of new patients who could not afford to take time off from work to get medical care. But budget cuts in 1989 forced CPH to close the evening clinics. The Congress Heights clinic is open one evening a week now, but only because top level CPH staff and volunteers have donated their time to see patients in the evening. While it is admirable that CPH executive staff members have been so generous with their own time, this is no way to run a basic health care system on which thousands of families depend. It is inexcusable that the city has not provided the resources to make the clinics more accessible to working families.

In 1987 CPH announced a policy of guaranteeing every pregnant woman seeking prenatal care an appointment within two weeks of a request. However, a June 1990 survey by CDF found that only three of the District's 11 clinics offering prenatal care services were able to

## Managed Care

A growing number of state Medicaid agencies have begun to incorporate managed health care arrangements (such as Health Maintenance Organizations [HMOs]) into their programs, particularly for families that receive AFDC, in hopes that they will help extend comprehensive health care to more families. Under managed care plans, a Medicaid participant is assigned to a health care provider and must go to that provider for all of his or her health needs. In theory, managed care programs prevent the inappropriate use of care, such as reliance on emergency rooms, and provide an incentive for preventive health care. Some studies show that managed care arrangements may reduce unnecessary and wasteful care and save money.

Managed care, however, is not a magic wand. Savings should not be achieved simply by limiting health expenditures. This is particularly true in the District, where high levels of infant mortality and childhood disability initially may necessitate more, not less, care for poor women and children. Yet many managed care programs may have financial incentives to minimize the services given to Medicaid-covered children regardless of need.

schedule an appointment within two weeks. One clinic did not have an opening until 39 days later. The average waiting time for an appointment was nearly three weeks.

The neighborhood health clinics' shrinking capacity has led to a sharp drop-off in the number of patients served in the clinics. Between 1985 and 1989 the number of pediatric visits in the clinics fell from more than 67,000 to less than 60,000. Family planning visits dropped from nearly 15,000 to less than 9,500. And dental visits plummeted from more than 44,000 in 1987 to less than 28,000 in 1989.

The District's approach to funding its clinics has been lacking in two respects. First, budget figures in recent years reveal that funds have been reprogrammed (or, in essence, diverted) from the public health clinics to other District government programs. Second, the District has failed to use federal Medicaid revenues to maintain and expand clinics' budgets.

A managed care program for children should offer several guarantees:

- All persons enrolled should be guaranteed year-long enrollment, regardless of changes in Medicaid eligibility. This will encourage families to enroll in plans and will encourage good service by the plan.
- There must be assurances of quality maternal and child health services. This will require guidelines about the benefits to be furnished or arranged for, the full range of agencies and institutions that will be used for specialty services, and the qualifications of plan providers and contractors.
- Plans should have service sites and service agreements with providers who treat poor families, providers who have evening and weekend hours, and providers who have satellite centers located in low-income neighborhoods. One of the ways managed care plans have been shown to save money, unfortunately, is by making services inaccessible and forcing people to go "out of plan" for care. The cost of out-of-plan care then is borne by other clinics and hospitals.

Since most public health patients are Medicaid-eligible, the District should take aggressive steps to capture Medicaid funding. This would include offering Medicaid application sites at all clinics, making applications simple, paying clinics a rate that covers their full, reasonable cost of serving Medicaid patients, and allowing clinics to retain revenues generated from Medicaid to hire staff and add hours and service locations. Instead the District has provided neither the Medicaid agency nor the public health department with the funding and staff needed to revamp the relationship between the two agencies, overhaul the enrollment process at the public clinics, and increase public clinic reimbursement levels. Thousands of Medicaid-eligible women and children go unenrolled until health problems intensify, and the health department and city continue to lose millions of dollars in federal revenues.

Poor coordination between health clinics and other programs complicates matters. For example, there is little integration of the federal Special Supplemental Food Program for Women, Infants, and Children (WIC) and prenatal care services provided in the clinics. A pregnant women seeking prenatal care cannot schedule a WIC appointment at the same time as her prenatal care visit. All patients must make separate appointments and often make two trips to the same neighborhood health center.

Moreover, the Commission of Public Health almost never bills Medicaid for Medicaid-covered services provided to Medicaid patients in the neighborhood clinics, and as a result loses important federal funds. The clinics routinely ignore whether reimbursement is available from an insurance plan (public or private) for pregnant women and children whose annual family income is less than $20,000, although virtually all the pregnant women would qualify for Medicaid.

## Recommendations

If Washington, D.C., is to ensure a healthy start for its children, every sector of the community must participate. Religious, civic, and social organizations must volunteer to assist pregnant women and children in their health needs. Families must encourage prenatal care use, immunizations, and other preventive care. Health care providers have a special role to play in educating and serving the community. Every physician in the District should accept Medicaid patients and serve a fair share of low-income residents.

But the District government cannot minimize its responsibilities to care for its poorest and weakest citizens. The costly and wasteful use of resources on unnecessary intensive care must be changed. Priorities must be reordered and innovative programs created. One proposal to raise the priority placed on public health programs is to create a cabinet-level Department of Health, separate from the Department of Human Services. Proponents argue that such a step would protect public health allocations from diversion to other programs. Such a change also might improve the chances of developing a more rational public health system. However, unless the deep structural problems that impair the performance of so many of the District health and human service programs -- too few staff, insufficient budgets, and underfunding of preventive programs -- are addressed, reorganization simply will paper over serious failings.

*Increase investments in prevention.*

- Fully immunize all children. Relieve pressure on the clinics by providing vaccine to private physicians free of charge. More clinic staff must be hired to administer inoculations to children in a timely manner and to conduct outreach campaigns to parents and community-based organizations.

- Expand the neighborhood clinics. Maternity and pediatric clinics must maintain evening and weekend hours to accommodate the needs of working families. Staffing levels must be increased to assure that all residents seeking care can receive quality medical services.

- Enhance prenatal care. The District can enhance benefits to pregnant women covered by Medicaid to include services that address a family's psychological and social needs, not just medical needs. These benefits include care coordination, risk assessment, nutritional counseling, parenting education, and home visiting.

- Implement federal EPSDT reforms. All of the city's Medicaid-covered children should receive routine preventive health assessments through EPSDT, and the services necessary to address problems identified through the exams. Quick implementation is especially important to children with chronic illnesses or disabilities with extensive medical needs, including those in the care of the city's child welfare and mental health agencies.

- Provide treatment services to drug and alcohol dependent women. Too few substance abuse treatment programs are available for pregnant women or women with children. Inpatient and residential treatment programs especially are needed to provide comprehensive intensive services, including prenatal care and postpartum and pediatric care, child care, nutrition assistance, and a range of other supportive services.

*Simplify Medicaid enrollment.*

- Simplify the Medicaid application for pregnant women and children. Currently, the Medicaid application is 10 pages long and discourages many eligible families from submitting a completed application. A one- or two-page application form would be far less intimidating and confusing to applicants.

- Place Medicaid eligibility workers in all publicly funded health clinics and hospital outpatient clinics. More families will enroll if Medicaid can be sought at the same time and in the same places as health services. It also will help the clinics recoup some of the costs of services provided.

- Develop Spanish-language applications to facilitate participation by Latino families. Culturally sensitive outreach programs should be developed to encourage Medicaid participation and preventive health care use.

*Maximize federal Medicaid revenues.*

- Increase Medicaid reimbursement for clinic services. Enroll in Medicaid all eligible patients who use the neighborhood clinics, and routinely bill Medicaid for the services they receive. This would allow the District to recoup funds that then should be used to help operate the clinics, expand services, and hire more staff.

- Enroll all eligible children in Medicaid. The District should provide active outreach, through schools, churches, day care, Head Start, and other child-serving programs, to enroll Medicaid-eligible children.

# Housing and Homelessness

Karen and her three children, ages four, six, and eight, shared a one-bedroom apartment with her brother until he asked them to leave in early January 1990. Unable to find a new place to live, they approached the city shelter system. The family was placed in a hotel room with one bed, no chairs, no table, and no phone. For the first few days the room had no heat and the children all caught colds. For meals, the family traveled by bus to the Pitts Hotel. The bus picked them up at 6:30 a.m., but breakfast often was not ready when they arrived at the Pitts, so the family waited outside or in the hallway. Sometimes they skipped breakfast so that the children could get to school on time. The children were still attending the school near their home in Southeast (the shelter and the Pitts Hotel were in Northwest), so Karen accompanied them on the bus to school. Since the family was not allowed into its hotel room between 10 a.m. and 7 p.m., they often waited in the hallway at the Pitts for most of that time. Later, after dinner, they would wait outside in the winter weather -- often for a long time -- for a bus to take them back to the hotel.

After a few weeks the family was transferred to another hotel, but they still had to go to the Pitts for meals, and their one room still had no table or chairs. In March the family was moved to a transitional housing program. The program staff told Karen to transfer her children to the school close to the facility so that her search for permanent housing would be easier. But the local school did not have room for her four-year-old, and she could not find affordable day care for him. This daily travail made it almost impossible for Karen to look for housing or participate in a training program.

Each night more than 1,300 children will go to sleep homeless in the capital of the Free World. Thousands more will sleep uneasily on the verge of homelessness. Every year, thousands of children and their parents desperately struggle to survive the horrors of homelessness. Children without homes wake up each morning trying to remember where they went to sleep, wondering if they will get enough to eat, and worrying that their clothes and toys will not make it through another day of traveling in search of food and shelter.

Rising poverty and an insufficient and shrinking pool of low-income housing units have created a large and rapidly growing demand for emergency shelter for homeless families in the District of Columbia. The best available data indicate that between 1985 and 1989 the demand for publicly supported shelter services more than tripled. As of the end of July 1991, there were 637 homeless families, including 1,387 children, at city-operated or funded shelters.

## Why Are Families Homeless?

Families are homeless here because of the wide gulf between family incomes and housing prices. Families often lose their homes in a crisis -- a layoff, domestic violence, or an uninsured health emergency -- but they become homeless, ultimately, because there is a desperate shortage of housing that low-income families can afford.

### Lack of Affordable Housing

While the number of poor families in the District has grown in the past decade, the low-cost housing supply has not kept up and is nowhere near meeting the need. In 1985 the Low Income Housing Information Service estimated that there were 46,545 low-income households competing for the 14,866 affordable units. The gap certainly has widened since then.

Low-cost housing is in short supply in the District for a number of reasons. During the 1980s the federal government cut funding for low-income housing programs by more than 80 percent, greatly restricting the number of new units that could be constructed. At the same time, many existing low-cost units were neglected and became uninhabitable. Others were converted into more expensive housing. Developers were given strong tax incentives to construct office and commercial space, not low-income housing, despite the current glut of the former and shortage of the latter. And according to the Service Employees International Union, underassessments of commercial real estate cost the city $146 million between 1986 and 1989 in tax revenues -- money that could have been used to create more low-income housing.

## Too Little Help With Housing Costs

Virtually all of the District's low-income families are eligible to receive housing assistance, but few get any help from the city and federal programs intended to help them. Insufficient federal and local resources, bad management, and skewed city priorities left almost two-thirds of District-area households with annual incomes of less than $10,000 and 85 percent of households with annual incomes between $10,000 and $20,000 without any help in 1985 (the latest year for which data are available). Many poor families have been on waiting lists for housing assistance for years.

The city's major housing assistance programs for low-income families are the federally funded Public Housing and Section 8 rental subsidy programs, in addition to the Tenant Assistance Program (TAP), a city-funded version of Section 8. Participants in all of these programs pay 30 percent of their income for rent -- the percentage recommended as affordable by the federal government -- and public funds supplement the remainder. In FY 1991 the District operated about 11,800 units of

### Who Are Washington's Homeless Families?

- Ninety-seven percent were District residents before they became homeless.
- Sixty-one percent have only one or two children.
- Forty-six percent are headed by parents older than 26; 11 percent are headed by parents younger than 21.
- More than half stay with friends or family before they seek shelter from the city.
- Most are eligible for housing subsidies but are not receiving them because of insufficient government resources.
- More than 600 families a night are sheltered by the city, many at a cost of about $3,000 a month per family.
- Many would require less than $500 a month in housing assistance to retain permanent housing.

public housing and maintained a waiting list of about 11,400 households. More than 2,300 public housing units -- almost 20 percent of the total -- are vacant and uninhabitable; many could be occupied with minor repairs. The Section 8 program serves about 1,750 households. The TAP program serves about 3,000 households, and the city estimates that 35,000 households are eligible to participate in the program. No new TAP certificates have been issued since December 1988, and the city has no plans to fund any additional certificates.

The FY 1992 budget will exacerbate these shortages by deeply cutting funding for the Department of Public and Assisted Housing, providing no additional funds for the TAP program, and cutting funds from programs responsible for the operation and maintenance of the city's public housing.

When families can't find affordable housing, and get no help with their housing costs, they end up spending most of their income for

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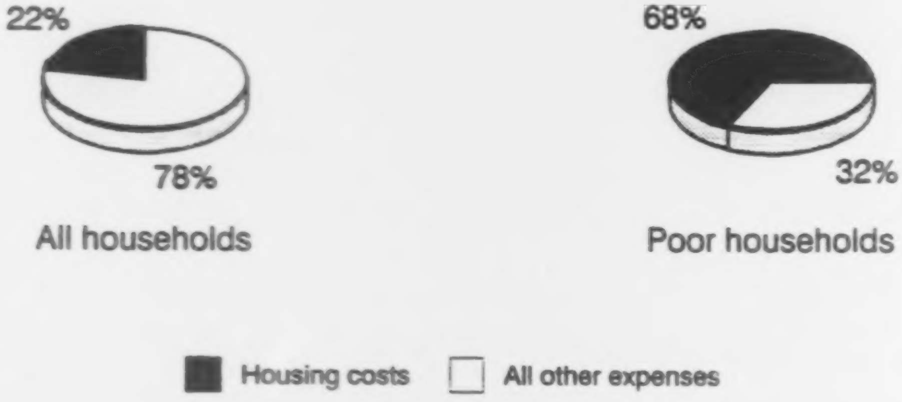
Median Housing Costs as a Percentage of Income,
District-Area Households,
1985



Source: American Housing Survey for the Washington Metropolitan Area in 1985, Bureau of the Census/HUD.

housing, moving in with friends or relatives (doubling up), or living in dangerously substandard housing. They teeter on the edge of homelessness.

A moderately priced two-bedroom apartment in the District costs about $700 a month, according to the U.S. Department of Housing and Urban Development (HUD), but many families can't afford to pay that much for housing. For example, a full-time minimum wage job yields about $640 in monthly income, and the maximum Aid to Families with Dependent Children (AFDC) grant for a family of three in 1990 was $409 per month. Most low-income families spend far more than the recommended 30 percent of their income for housing. Overall, area households spend an average of 22 percent of their incomes for housing, but among poor households the average is 68 percent, far in excess of the recommended 30 percent.

## Doubling Up and Overcrowding

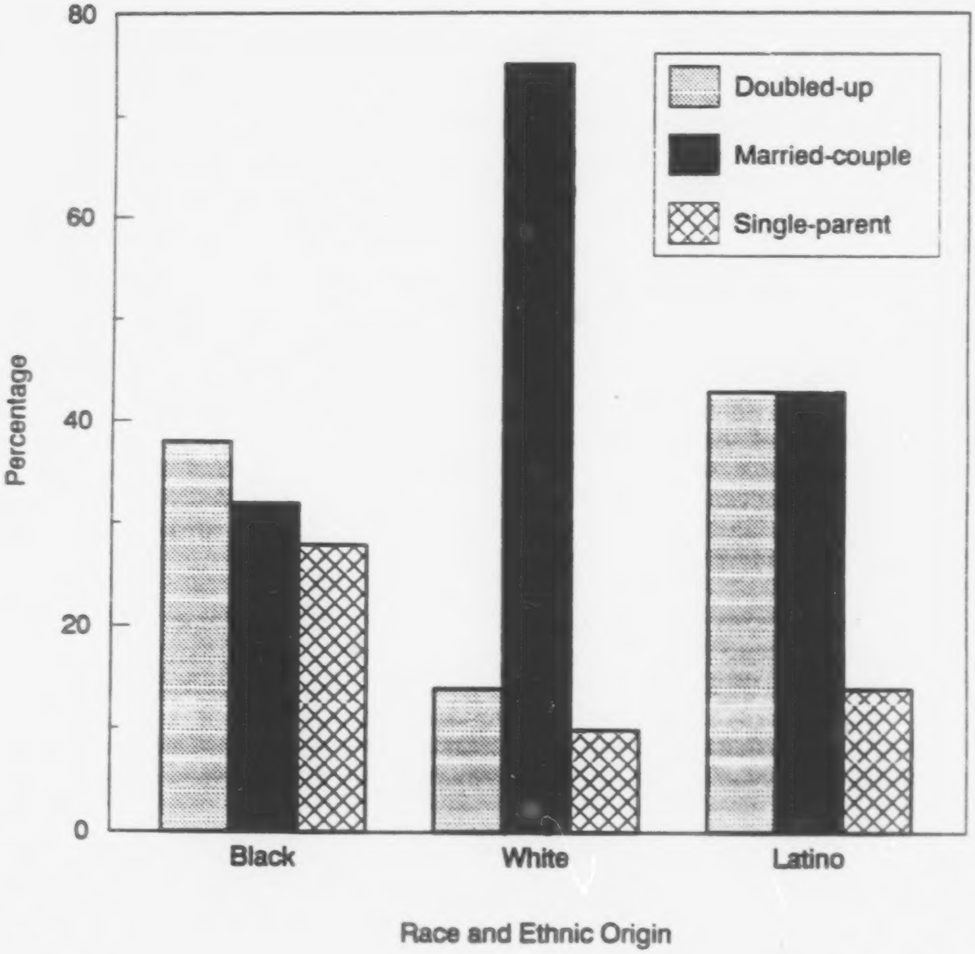
When families no longer can carry the costs of their own housing, they often are forced to move in with friends or relatives. According to a 1989 city report, more than one-third of all District children live in doubled-up households. Families of all racial and ethnic groups double up, but because doubling up is overwhelmingly associated with poverty, Latino and black children are much more likely to be doubled-up than are white children. Thirty-eight percent of black children and 43 percent of Latino children live in doubled-up households, compared with 14 percent of white children, according to the city's report.

Doubling up is not always problematic: it can be a stable and permanent arrangement that allows two or more families to share housing expenses as well as child care and other household responsibilities in a unit big enough to accommodate several families. For example, 50 percent of Washington's young children living in doubled-up households are cared for by another household member while their mothers work.

Unfortunately, for many families doubling up is not a stable arrangement, but rather a stopgap strategy to keep a roof over their heads. These families are at high risk of homelessness -- the "guest" family may be asked to leave when the overcrowding and attendant tensions get too high, when a new baby arrives, or when they are discovered by the landlord and the "host" family is threatened with eviction. Unless they can make other arrangements quickly, they end up among the homeless.

In 50 percent of the cases of sheltered families recently reviewed by the city, families came to shelters from the homes of friends or family. Another 22 percent report that they became homeless because of overcrowding, suggesting that they were doubled up -- or even tripled up.

## Where the District's Children Live, by Household Structure and Race/Ethnic Origin



Source: Census 1986.
Prepared by the Office of the Mayor, February 1989.

### Inadequate Housing

The shortage of decent and affordable housing forces many poor families into housing with dangerous conditions: inadequate heating, peeling paint, lead dust, and faulty electrical systems. Some homeless families are fleeing such conditions -- they can't stay when the heat breaks down in the winter or a child is poisoned by lead paint and dust, and find themselves with nowhere else to go. Others who live in substandard housing end up homeless when they are evicted by landlords in retaliation for their complaints about poor conditions.

### Other Family Problems

Other stresses and problems can make families particularly vulnerable to homelessness. People who work with homeless families in the District, and those who conduct research in other parts of the country, identify in particular the role of domestic violence, substance abuse, and a fragile personal support system in propelling poor families into homelessness. Although families at all income levels are afflicted by such problems, the additional strain easily can destroy the tenuous hold that low-income families have on their housing.

## Homelessness Hurts Families With Children

Homelessness negatively affects a child's health, nutrition, schooling, emotional health, and development, and threatens the stability and emotional security of the family itself.

### Poor Health

The conditions of homelessness and poverty can damage the health of children and their parents severely. Like other poor children, homeless children's health is generally worse than that of their nonpoor peers, and they often lack basic and preventive health care. Many are not properly immunized.

All homeless families in the District theoretically are eligible for services at the city's public health clinics, but few have transportation to get there. In addition, clinic waits of several hours can be difficult, especially for homeless families who can't miss rigidly scheduled meals and will risk losing a place to sleep if they are not at the shelter at certain times.

The routine illnesses -- colds, stomach ailments, and ear infections -- that affect all children often become serious for homeless children. In addition to inadequate health care, many suffer because they spend a lot of time outside, regardless of the weather, moving from shelter to shelter for meals or simply looking for new housing. Finally, many children get sick because shelters often are crowded and unsanitary environments where contagious diseases spread easily.

Health Care for the Homeless, a nonprofit agency, has tried to fill in the gaps for homeless families by providing preventive and basic health care from medical trailers and clinics in some of the hotels used as shelters. But insufficient resources and bureaucratic obstacles have prevented their services from reaching all the homeless families.

## Inadequate Nutrition

Food should not be a luxury for homeless children, but city policies often have treated it as such. Children's nutritional health has been endangered by unreliable, inflexible, and nutritionally unstable feeding arrangements.

Homeless families in shelters do not have facilities to cook and are dependent on the city services for their meals. In many cases, families have to travel from the shelter where they sleep to another location for meals. These families often have to choose between getting their children to school on time or taking them to breakfast. Families also have been hurt by policies in the food stamp program, which discouraged applications from eligible families and did not process applications within appropriate time frames. The Washington Legal Clinic for the Homeless, Neighborhood Legal Services, and a private law firm sued the city on behalf of persons who are eligible for food stamps, including people who are homeless. The parties have reached a settlement that should make it easier for families to receive food stamps.

The special dietary needs of homeless infants, children with allergies, and pregnant women often are not met. Infant food generally is distributed only once a day, and rigid meal times make it difficult to feed toddlers who need more than three meals daily. Until recently the city provided families with infant formula that required refrigeration, but families did not have refrigerators. Parents often had to choose between letting their infants go hungry or serving them formula that had been open at room temperature for hours. Formula that does not need refrigeration now is finally available. Programs such as Martha's Table, which offers after-school and weekend snacks, help fill the gap, but they cannot reach all the hungry homeless families.

## Education and Development Shortchanged

Children's educational achievement can be damaged irreparably by homelessness. According to federal law, homeless children may continue to attend their old neighborhood school or transfer to the school near the shelter, whichever is determined to be in their best interest. Many of the District's homeless children are not in school at all.

In September 1990 the National Law Center on Homelessness and Poverty reported that transportation was the most significant barrier to education facing homeless school-aged children in the District. More than half of the families interviewed reported that they had to keep their children home sometimes because they did not have access to tokens or money for public buses. Some parents, determined that their children not fall behind in school, spent $80 a month of their meager incomes for public transportation. Almost 20 percent reported that they had transferred their children to the school near the shelter because of money, even though they thought it would be better for their children educationally to stay where they were.

Transferring a child to a school near the family's shelter can be problematic. Children may be out of school while their records are being transferred, and once in school the adjustment can be difficult. Families rarely receive help from the school system, despite the responsibility of school administrators to ensure the enrollment of homeless children.

Whichever school they attend, homeless children's education often is hindered by the uncertainty and chaos of their everyday lives. Because homeless families often sleep, eat, play, and live in one room, children have no quiet or private place to study or do homework. Their families often cannot afford to buy them the school supplies they need. School children often are ashamed to reveal that they are homeless, and some are so embarrassed by the teasing and taunts of other children that they simply refuse to attend school.

Although it is hard to eliminate the emotional stresses of homelessness, teachers and other staff members in schools located near shelters have tried to help. Some spend their own time and money to provide children with clean clothes and school supplies. In 1990, for the first time, the D.C. public schools worked to provide all homeless children in the city's shelters with notebooks and other school supplies at the beginning of the school year. Community organizations and projects, such as the D.C. Mental Health Association, the Jewish Community Center, ZEST Inc., Project Northstar, and others, provide tutoring and other activities that help buffer the impact of homelessness on children's education.

Preschool-age children also suffer the negative effects of homelessness. Families often report that their younger children are delayed in achieving developmentally important milestones. For example, because families may spend hours waiting in various hotels for meals or health care, infants often are restrained in strollers and are slow to learn to crawl and walk. Some parents report that their children actually regress after they become homeless, going back to diapers or losing vocabulary.

### Family Separation

Sometimes homelessness separates family members at precisely the time they need each other most for support. Many shelters will not take two-parent families unless the parents can document that they are married or that the man is the children's father. One father slept outside a shelter in his truck because he could not produce the documentation required to let him join his family inside. Often, parents send older children to stay with friends or relatives when they become homeless, hoping to spare them the horrors of shelter living. Some families, in desperation, place their children in foster care to spare them from the cold of the streets or the conditions in the city's shelters. Some children cannot return home from foster care because their parents are homeless.

## The District's Inadequate Response to Family Homelessness

The horrors of homelessness for families and children have been compounded by the city's fragmented and inadequate response to their needs. Since 1986 the city has released a Comprehensive Plan for Homeless Families, sponsored more than one conference on homelessness, created a Mayor's Coordinating Council on Homelessness, and supported the development of a Community Partnership for the Prevention of Homelessness. All have recommended that the city focus on preventing homelessness by increasing the availability of low-cost housing and providing neighborhood-based comprehensive services, reducing the use of expensive hotels to shelter families, and helping those who do become homeless return quickly to safe and stable housing.

But despite the myriad recommendations, too few real improvements have been made. Homeless families are shortchanged by the city's inefficient and shortsighted administration of programs and services. Families and children are hurt every day by the city's lack of planning, lack of coordination among responsible agencies, and inefficient and inappropriate use of federal funds for services and programs. Although thousands of families have become homeless in the District in recent years, only minimal city resources are being devoted to preventing homelessness or addressing its root causes: poverty and inadequate housing. Instead, the city continues to focus most of its resources and staff energy on expensive and often inhumane emergency shelter.

## Lack of Coordination

The multitude of agencies responsible for services related to housing and homelessness demands a commitment to coordination. The Office of Emergency Shelter and Support Services (OESSS), a division of the Commission of Social Services, is responsible for the provision of emergency shelter and services. The Department of Public and Assisted Housing (DPAH) oversees the city's low-income housing programs, including TAP and public housing. The public schools are responsible for helping homeless children stay in school. The Commission of Public Health helps support Health Care for the Homeless. Other administrations in the Department of Human Services are responsible for AFDC and other income support programs and also are responsible for children placed in foster care because of their families' homelessness.

Although these agencies often work with the same families -- and may have worked with them before they became homeless -- they rarely coordinate their efforts. For example, the almost total lack of coordination between OESSS and the D.C. public school system has interfered with homeless children's ability to attend and achieve in school. Recent efforts at collaboration are more promising: DHS and DPAH have agreed to provide shelter and services to homeless families through MUSCLE (Ministries United to Support Community Life Endeavors), a nonprofit housing developer. DHS has agreed to provide services for homeless families placed in housing units that are leased by DPAH and operated by MUSCLE with an emphasis on helping families return to stable and permanent housing. To date, however, the range of services promised by the city is not being provided for the 57 families housed by the program.

## "Welfare Hotels" a Bad Choice

Unfortunately, as in many cities, the District's primary response to the homelessness crisis over the years has been to place families in hotel rooms; it is a bad choice.

First, although convenient, hotels are an extremely expensive way to shelter families. Many communities rely on hotels to shelter families because rooms can be secured easily and the number can be adjusted quickly as the size of the homeless family population changes. When the city places families in hotel rooms, it pays the cost of the room and the cost of food, security, and staff. The cost can be $100 per day, or $3,000 per month per family, far more than it would cost to subsidize the family's rent in a safe and stable apartment. Federal funds are available to share the cost of shelter through the Emergency Assistance program, which is part of AFDC (often referred to as welfare) -- thus the term "welfare hotels."

Hotels also are horrible environments for homeless children and families. The conditions and locations of the hotels can cause or exacerbate many of the problems homeless families face. Reports by the D.C. Mental Health Association and others in 1989 and 1990 outlined the horrors: many of the hotels were dilapidated and dirty, rodent- and roach-infested, and crowded with entire families living in one room with one bed. Most did not have facilities for food storage or preparation, and families often traveled to other parts of town for their meals. Many hotels are simply dangerous: in 1988 a homeless child died in a hotel when an unsecured stove fell on her; in 1989 a child died in a fire at the Capitol City Inn, which previously had been cited for 1,500 fire and building code violations. Homeless families often were forced to share their hotel shelter with prostitutes and drug dealers; many parents were afraid to let their children leave their rooms.

Homeless families in hotels today still encounter many similar problems. Most homeless families are sheltered in facilities far from their own neighborhoods. The dislocation makes it hard for families to find new housing or keep their children in school. The valiant efforts of the social workers assigned to help hundreds of families in hotels is critical, but they are overwhelmed and unable to provide services to all the families that need them.

### Alternatives to the Hotels

As shelter costs and public criticism have escalated, and as D.C. City Council action has intensified and litigation increased, the city has been phasing out its use of hotels to shelter families. The daily hotel population has fallen between 1989 and 1991, but it has happened slowly, erratically, and without evidence of long-term planning. For example, families from the Capitol City Inn were not finally moved out until December 1989 and although they benefited from a one-time allotment of Section 8 housing subsidy certificates from HUD, such arrangements typically are not made. In early August 1991 approximately 224 families were still in hotels, and an additional 413 families were living in apartment-style shelters, some in conditions just as bad as those in hotels.

In 1987 the City Council attempted to address a number of problems in the city's homeless shelter system with enactment of the Emergency Shelter Services for Families Reform Act. This law requires that families be offered apartment-style shelter after a maximum of 15 days in hotels, that shelters be located in communities across the city, and that community resources be established to provide services to homeless families. The new law essentially was ignored by the city until a class action law suit was brought successfully on behalf of families living in hotels. The city since has taken some steps to comply with the 1987 law by increasing the number of non-hotel shelter facilities and supporting some community service efforts, such as the MUSCLE program, but it has done so very slowly, even as the number of families in shelter has stayed high. Because the court's decision rested in part on the right to shelter adopted in the referendum called Initiative 17, which since has been overturned, the city is appealing the court's decision.

## Transitional Housing

As the city tries to reduce the use of hotels and other emergency shelters, it has turned increasingly to transitional housing programs, which offer apartment-style shelter and social services. Although these programs generally are more humane placements for families than hotel shelter, they are not the ideal solution to the city's homelessness crisis. Transitional living is not the permanent housing that families and children need. After a predetermined period, usually between three and 18 months, families have to leave again to find permanent housing.

Some nonprofit organizations, such as the Community of Hope, are doing a good job of providing families with transitional housing as well as comprehensive support services. The cost to the city is far less than housing families in hotel shelters, but it is still much more expensive than subsidizing a family's costs in permanent housing. The situation is worse in transitional housing programs operated by for-profit businesses. Such operations often provide minimal services and temporary quarters for which the city is charged almost as much as the hotels -- up to $93 a day. In addition, the city has placed some families in these programs as if they were emergency shelters: at one time up to five families were being placed together in one-bedroom apartments in a program that offered almost no services.

Transitional housing is not necessary for all homeless families. The concept of placing homeless families in transitional housing, rather than helping them move directly from emergency shelter to permanent housing, rests on the premise that homeless families are not capable of independent living. They are assumed to need a very structured setting, usually complete with curfews, rules, work requirements, and supervision. Although some homeless families benefit from this kind of program, many could live on their own with necessary services provided to them where they choose to live.

The city, however, has discontinued support for some important efforts to provide effective services to help maintain families in permanent housing. ConServe, for example, a nonprofit consortium of agencies, assisted homeless families by helping them find housing (subsidized by TAP certificates), and then providing them with necessary support services for one year. ConServe estimates that it costs approximately $817 a month to serve each family (including social services and the housing subsidy). But in 1989 the city stopped funding ConServe, claiming that it could only afford to provide the emergency shelter mandated by Initiative 17 and no longer could provide other kinds of services. This was an extremely shortsighted decision, since ConServe had saved the city almost $1 million in services for the 200 families it had helped move into permanent housing since being established.

### Homeless Families and the Right to Shelter

In 1984 District voters enacted Initiative 17, formally known as the D.C. Right to Overnight Shelter Act of 1984, which established an entitlement to decent, emergency, overnight shelter for any homeless individual or family in the District of Columbia. Prior to its passage families routinely were turned away from full shelters; after it passed the city was obligated to ensure sufficient shelter space for all who needed it.

Initiative 17 was repealed in 1990 and replaced with the D.C. Emergency Overnight Shelter Amendment Act of 1990, which removes the right to shelter and limits shelter to 90 days for families. The repeal of Initiative 17, combined with the city's failure to implement the provisions of the Emergency Shelter Services for Families Reform Act, could send thousands of homeless children and families back to the streets, their cars, and abusive homes.

### Little Preventive Investment

As both the human and fiscal costs of family homelessness have continued to rise, the city has begun promising but limited efforts to prevent family homelessness. For example, the Office of Emergency Shelter and Support Services employs prevention workers who try to locate families scheduled for eviction by the U.S. Marshals. OESSS workers try to obtain Emergency Assistance funds to pay late rent for families facing eviction because of nonpayment (about 95 percent of eviction cases). Although this often does prevent homelessness, OESSS's prevention effort is severely understaffed, and its effectiveness is hindered because families are reached so late. The Anacostia/Congress Heights Partnership for the Prevention of Homelessness, a satellite office of the Community Partnership for the Prevention of Homelessness, works to identify families at risk of homelessness in Anacostia and to provide them with assistance to help them stay in their homes. OESSS also has been helpful in linking identified families with Emergency Assistance and other services.

Community organizations, including many religious groups, also operate homelessness prevention efforts, such as informal loan and grant programs, and more structured adopt-a-family programs that link congregations with a family or families in need of assistance.

### Bad Management

Finally, bad management in the public housing authority has cost the city both funds and units that could have housed many families: in the past 15 years the District has failed to spend $47 million in federal rehabilitation funds. The city once spent $1 million removing lead paint from dilapidated units scheduled for demolition. Repeated cuts of housing funds and decisions not to add resources to the popular TAP program have contributed to the shortage of safe and affordable housing units. Nonprofit housing developers, such as Manna, MUSCLE, Marshall Heights Development Corporation, ARCH, and others, work constantly to create additional units, but they cannot replace needed federal and city financial investments and political commitments.

Public housing residents, and families waiting for public housing units, are hurt by federal and city budget cuts, underuse of federal funds, staff shortages, and bureaucratic incompetence. While more than 11,400 households wait for public housing, approximately 2,300 vacant units remain unrepaired, and repairs needed in occupied units are ignored for so long that these units, too, become uninhabitable. Minor repairs on vacant units in 1990 took 230 days on average to complete; the HUD standard is one to five days for such repairs. A D.C. Auditor's report found that many units in need of minor repairs remain vacant for so long that they are reclassified as units in need of major repairs. Many of the repairs that are done are of poor quality -- almost one-half of the DPAH units that have been inspected fail to meet federal housing quality standards. The city's efforts to provide housing assistance to families are hindered by the fact that one-fourth of all the budgeted staff positions at DPAH are unfilled, and the agency itself has had five directors in the past five years.

## Recommendations

All segments of society -- federal and local government, business, nonprofit organizations, religious organizations, and other community groups -- have important roles to play in ensuring every family a decent, permanent home. The costs of homelessness to our city both in terms of the potential long-term damage to children and the financial costs of emergency shelter are too great to bear.

The District government must take the leadership role in working to prevent homelessness among families. Families should have adequate income supports, and supports for especially vulnerable families should be strengthened through comprehensive social programs. The District should work to expand the supply of affordable housing and rental subsidy programs, while assuring that families that do become homeless are guaranteed decent apartment-style shelter and are assisted in returning to permanent housing.

### *Increase access to low-income housing.*

- The District must work in partnership with the federal government, nonprofit and for-profit developers, and banks to increase the city's low-income housing stock. This should be done through construction of additional low-income housing units, rehabilitation of vacant public housing units, and expansion and careful oversight of the Tenant Assistance Program to ensure that families in need receive appropriate assistance.

- The District should increase both staff and funding for housing assistance programs under the Department of Public and Assisted Housing. The city should use more efficiently all federal funds available for these purposes. In addition, more local funds should be collected and committed to housing programs. For example, commercial real estate taxes should be assessed and collected properly. Strong linkage requirements should be promoted and enforced so that developers of commercial and luxury real estate contribute either low-cost units or financing for low-income housing. Additional city support should be provided to nonprofit housing development groups for both renovation and construction of low-rent units.

*Expand homelessness prevention activities.*

- The District should focus on homelessness prevention, mobilizing all possible sources of funding and programming to identify and assist families before they become homeless. AFDC Emergency Assistance and special needs program funds can be used to help families cover back rent and other emergency needs. Federal programs funded by the Stewart B. McKinney Homeless Assistance Act can support prevention activities as well as critical services to homeless families. Successful community efforts that assist low-income families at risk of becoming homeless should be expanded with both city and private funds.

- The District should post a prevention worker from the Office of Emergency Shelter and Support Services in landlord-tenant court, and should include information about available resources (such as Emergency Assistance) on all relevant materials, such as eviction notices.

- The District should help homeless families move back into permanent housing as quickly as possible. This will require the provision of social services, case management, housing search assistance, and other necessary supports to all families immediately after they become homeless. Whenever needed, homeless families should continue to have access to support services once they are reestablished in permanent housing. High-quality, comprehensive, transitional programs should be available as an alternative for families that need special assistance to live independently.

*Improve the shelter system.*

- By July 1992 the city should stop using hotels to shelter families. The city should implement immediately the provisions of the Emergency Shelter Services Reform Act and comply with injunctions now pending that require: the provision of apartment-style shelter to all families after a maximum of 15 days in hotels, the dispersal of shelters in communities around the city, and the provision of services to help families reestablish self-sufficiency.

- In addition to complying with these mandates, the city should enforce basic health and safety standards for shelters so that families and children are not endangered during their stays there, and improve coordination between city agencies to help families return to permanent housing, to help families get access to all necessary services, and to ensure that homeless children are able to continue attending and achieving in the school of their choice.

# Vulnerable Children and Adolescents:

## In the Hands of the Child Welfare, Mental Health, and Juvenile Justice Systems

Thousands of children and adolescents are in crisis in the District of Columbia. They are not cared for or nurtured adequately. Many have been abused, neglected, or abandoned. Some have emotional disturbances or physical disabilities that are treated inadequately. Some get in trouble with the law. Others have been victimized by the very child-serving systems designed to help them.

Many of these young people have parents who are overwhelmed by the stresses of poverty or who assumed parenting responsibilities long before they were ready. Some families have been ravaged by alcohol or other drugs. Other families have been unable to find help for their children's special needs, despite repeated appeals for assistance. Growing child poverty, increasing numbers of births to unmarried teens, increasing numbers of homeless families with children, and the crack cocaine epidemic in the city have added to their numbers and made them even more fragile.

These families and children often have multiple needs and are beset by constellations of interrelated problems: chronic financial stress, inadequate housing, inconsistent medical care, and numerous school problems. Too frequently the city's health, education, and substance abuse systems have failed these children. They then come to the attention of the child welfare agency or end up in the mental health or juvenile justice systems. But these systems, too, are in crisis – and children's needs continue to go unmet or their conditions worsen.

Labels get attached to these children, such as "abused," "neglected," or "dependent"; "seriously emotionally disturbed," "PINS" (persons in need of supervision), or "delinquents." Sometimes they get divided into "good kids" and "bad kids," "troubled kids" or "troubling kids." Such labels, however, frequently mask their multiple needs, their similar backgrounds, and the common costs of their sad plight.

This chapter examines the status of vulnerable children and adolescents and their families in the District and the city's sorely inadequate response to their plight. It highlights their similar needs and the common problems plaguing the city's child welfare, mental health, and juvenile justice systems.

## Children and Families Are in Crisis

Some sense of the vulnerabilities experienced by thousands of children and families in the District of Columbia can be obtained from statistics -- some make the newspaper headlines, others do not. These data help portray the challenges facing child-serving systems, helping professionals, the city's leaders, and the community at large as they attempt to the meet the needs of these children and families.

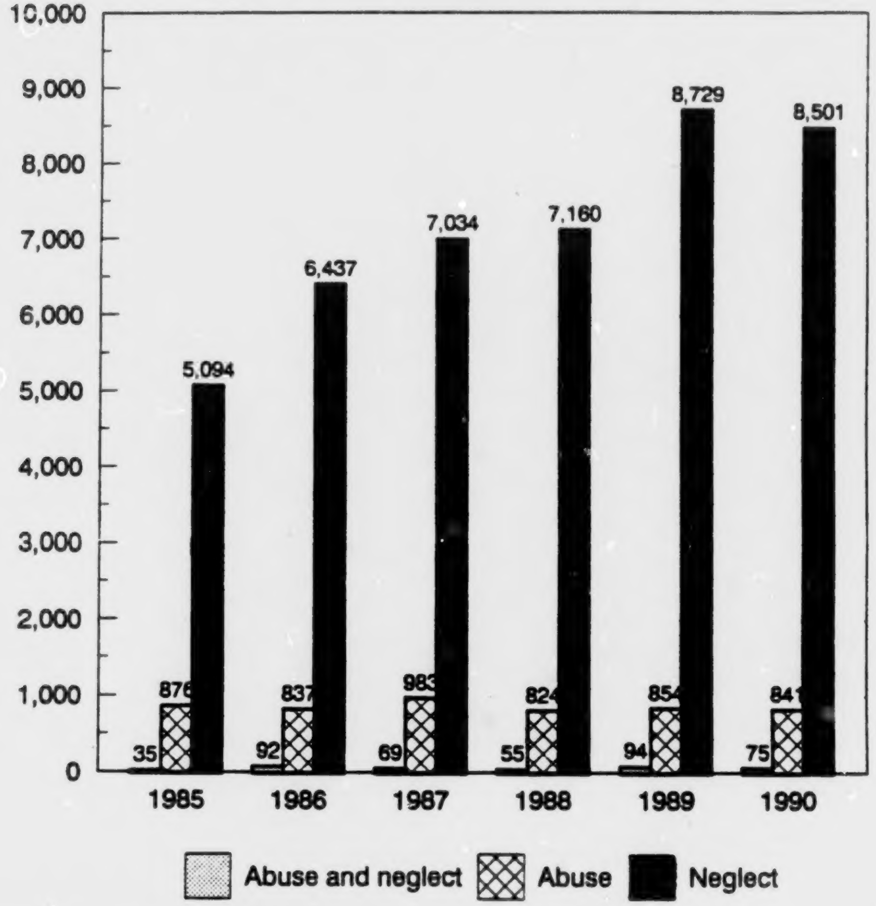
- In FY 1990, 9,417 children -- 25 a day -- were reported abused and neglected. The vast majority of these children, 91.1 percent, were involved in reports of child neglect -- children left unattended or without adequate shelter and supports. In the past five years the number of children involved in neglect reports has increased by almost one-third. Officials responding to these reports estimate that 50 to 80 percent involve families in which there are drug or alcohol problems.

- The average monthly number of children in foster care (foster family homes, group homes, and residential treatment centers) increased 10.3 percent between 1988 and 1989, and reached 2,313 in FY 1990. It is projected that more than 3,100 children will be in care by 1995. The number of very young children -- younger than 23 months -- increased 43 percent between 1988 and 1989. An estimated three-fourths of the children in care are from families receiving Aid to Families with Dependent Children (AFDC).

- More than 16,000 children in the District of Columbia -- 11.8 percent of all children -- need mental health services. An estimated 6,800 children have serious emotional problems or are at risk of developing serious emotional problems. Some of these children's problems have biological origins. Others result from histories of parental neglect or abuse or maltreatment at the hands of the system. Still others may be drug related. Many children's problems are exacerbated by the difficult situations in which they live.

- In FY 1989, 2,808 youths were arrested and had their cases petitioned for delinquent acts in D.C. Superior Court. Some have abuse or neglect in their backgrounds. Many have educational deficits that started much earlier. Some come from the child welfare system. A number are close to their families, but their parents are plagued with financial, mental health, substance abuse, and housing problems. Some have felt hopeless for years.

### Children Reported Abused and Neglected in the District of Columbia, 1985-1990



Sources: 1985-1990 data from 1990 Indices, D.C. Government, July 1990; 1990 data from Family Service Administration staff.

There are real faces behind each of these statistics:

"Tina," now three years old, has been in institutional care since she was abandoned by her mother two years ago. What was to have been an emergency placement has become a permanent placement. Although her mother came to see her three months ago, the agency says it can't locate her. Her grandmother feels unable to care for Tina full time. She says her daughter has been in and out of drug treatment and seems to be doing a bit better but now has no place to live. A volunteer at the institution has expressed an interest in providing a foster home for Tina, but can't get the agency to respond. Tina, meanwhile, lingers in care with only the city as a parent.

"Mary" soon will turn 21 years old and be discharged to her own responsibility. She has been in foster care since the age of one, but parental rights were never terminated, even though she had no contact with any family members. There is no record of the initial cause for placement. Mary's emotional problems have intensified, and she has been in and out of residential treatment settings. She also has been in and out of special education. Numerous foster home placements didn't work out. She has run away from her current foster home and is refusing to cooperate with plans for discharge.

"Lemoyne," a 15-year-old on probation for stealing a car, is not atypical. He reads and does math at the fourth-grade level; he is repeating seventh grade and is frequently truant. Although Lemoyne's difficulties concentrating in school might have been sufficiently severe to qualify him as disabled, he was never referred for a special education assessment. Lemoyne's mother is a crack addict and his father is at Lorton. His probation officer says he has been "raising himself" for a long time. Last year the family lived in a homeless shelter for six months. Lemoyne's youngest sister is in a therapeutic nursery with severe speech delay. Lemoyne is the father of an eight-month-old child who is in foster care.

## A Complex System Fails To Meet Complex Needs

The needs of these children and adolescents and their families are terribly complex. So, too, are the systems designed to protect them and respond appropriately to their needs. It is not unusual for one or more public or private agencies, the police, and the courts all to be involved in efforts to assist an individual young person or family.

There is no single entry point for help. In many cases, formal entry into the public agency's care is preceded by involvement with the courts. Children who are reported as abused and neglected are brought to the court when the report is substantiated and intervention is believed necessary. Juveniles charged with status offenses (acts, such as truancy or running away, that are considered offenses only by virtue of the offenders' status as juveniles) or delinquent acts also need to go before the court for a determination of their legal status. When there is court involvement, the Office of the Corporation Counsel also is involved, and often attorneys from the Counsel on Child Abuse and Neglect, the Volunteer Attorney's Office, or Public Defender's Service, who may be called upon to represent the young people themselves or their parents.

The police, too, are involved with a large percentage of these children. The District of Columbia is one of the only jurisdictions in the country that continues to give the police sole responsibility for investigating all reports of physical and sexual abuse. Obviously the police also are involved in arrests of juveniles and the subsequent investigation and prosecution of their cases.

Within the umbrella agency of the Department of Human Services (DHS), three different commissions and four different administrations have responsibility for meeting the needs of different groups of these children and adolescents, and sometimes for the varied special needs of a single child and family.

The Child and Family Services Division (CFSD) in the Family Service Administration in DHS is charged with investigating reports of child neglect, protecting children from abuse and neglect, preventing the unnecessary separation of families, providing out-of-home care for children who must be removed from their families, enhancing reunification, and ensuring adoption for children who cannot be reunited with their families. The division in turn contracts with the Consortium for Child Welfare -- a group of private agencies -- to provide foster family and group home care and related services to more than 400 of the division's 2,300 wards.

The Youth Services Administration (YSA) deals with youths in the juvenile justice system. YSA is charged with developing and providing delinquency prevention activities. It accepts commitments of youths who are being detained pending trial, youths who have been adjudicated delinquent by the courts, or youths charged with status offenses who are referred to as persons in need of supervision (PINS). PINS generally are referred for alternative services. The majority of the delinquent youths are placed in institutions; some are in foster homes, group homes, or residential treatment centers, and about 19 percent remain at home.

The Commission on Mental Health, through its Children and Youth Services Administration (CYSA), is charged with providing mental health treatment for children with emotional problems, those who are wards of the city as well as other young people. This includes arranging and paying for both in-home and out-of-home treatment.

Regardless of the door through which children enter care, or the labels attached to them, children face similar barriers to receiving the help and support they need. In many instances the District government fails to provide even the basic protections mandated by state and federal laws. Systemic problems harm children and adolescents in the child welfare, mental health, and juvenile justice systems.

### Preventive and Early Intervention Services Severely Limited

The Child and Family Services Division (CFSD) is supposed to assist families and alleviate crises impeding their ability to care for their children. However, few resources are targeted toward such preventive efforts. The inadequate supply of child care in the District, particularly for young children and children with special needs, as well as the lack of appropriate health care, increase family pressures. Too frequently families with problems have no place to go before crises intensify and CFSD confirms a report of abuse or neglect. Although CFSD workers can use the AFDC Emergency Assistance program to assist families in crisis, there is a $50 limit on funds available to resolve a crisis and assistance can be provided for no more than 30 days in any 12-month period. As of June 30, 1990, fewer than 50 of the 1,200 families in the CFSD's Intensive Services Branch were receiving day care, homemaker, or emergency shelter services.

Abused or neglected children in the District of Columbia are removed from their homes more than twice as often as the national average, and often without services first being provided to prevent unnecessary placements. The 137 children entering foster care in the District for the first time from January through March 1991 accounted for more than one-third of the total placements during that period in the Washington, D.C., metropolitan area. Lack of parenting skills was at least partly responsible for many of these placements, according to the Metropolitan Washington Council of Governments June 1991 survey.

There also is a lack of appropriate programs to address the multiple needs of families with drug problems. As a result, children born drug exposed are referred to child protective services because the public health system and substance abuse treatment system cannot offer them or their parents the supports that are needed. Drug or alcohol abuse was a factor in the placement of almost 25 percent of the children who entered foster care in the first three months of 1991. In the case of 19 children, placement was necessary because a parent or other caretaker was admitted to a drug treatment program. There are not enough in-home nursing services that assist drug-involved and other high-risk families, such as the Perinatal Outreach Project, jointly operated by Children's National Medical Center and the D.C. Office of Maternal and Child Health. Too frequently drug treatment programs cannot accommodate mothers and children together.

Federal and District laws require that the city make reasonable efforts to prevent the separation of children from their families. However, in FY 1990, while the Department of Human Services spent almost $36 million to support children in foster care, very little was spent on in-home crisis intervention and family preservation services. Ironically, however, the city's limited experience with intensive family-based crisis intervention shows some of the same positive results that other communities have seen from family preservation services.

The District's Preventive Family Counseling Program worked with 413 children from its inception in September 1986 through 1989, and only 23 of these children were placed in foster care. Workers with caseloads of five families each spent up to six months with a family, visiting an average of four or five times a week. The staff investment certainly paid off when compared with the cost of putting children in out-of-home care. Yet the number of families and children served by the program has been declining because of severe staff shortages. As of mid-1990 only one worker remained.

Recent reports by the Commission on Budget and Financial Priorities (the Rivlin Commission) and the Center for the Study of Social Policy have recommended the establishment of fully staffed Family Preservation Units to serve as gatekeepers at the door of the child welfare system. Such intensive family-based crisis intervention service programs, which are now at least being piloted in 30 states, serve caseloads of two to four families for no more than six weeks; they protect the child, address the problem at hand, often make discretionary funds available, and, where necessary, link the family with other services. The Center's report, *Children and Family Services in the District of Columbia*, estimates that a trained staff of 25, with five supervisors, could serve 560 families per year in which children were at imminent risk of placement. It estimates a net savings from the family preservation program of more than $2 million within two years of operation.

Preventive efforts also are lacking for children with serious emotional problems. CYSA staff members have started developing early intervention and day treatment programs for these children, but far too few children are served. The city has a long way to go to meet the goal established in the 1986 Mental Health Implementation Plan, which set out a schedule for the development of a full continuum of mental health services for children, youths, and families.

- The Parent Infant Development Program for mothers with histories of psychiatric problems serves 45 parents but is operating at less than 50 percent of its staff capacity. The program's goal is to serve 150 of these especially vulnerable families. Current intake has been closed and attempts to move the program from the grounds of St. Elizabeth's Hospital and into the community have been stalled.

- CYSA operates three therapeutic nursery programs in the public schools, which have room for 30 children. No new referrals can be served. The original goal in the Mental Health Implementation Plan was 10 therapeutic nurseries.

- The city's five psychoeducational day treatment programs serve about 200 children, far fewer than the number who could benefit from such programs. A portion of children who need such services currently are placed in more costly residential settings. One day treatment program is serving 80 youths, approximately 10 percent of whom had been in residential treatment and 34 percent of whom had been in jail.

Many of the youths who end up in the juvenile justice system have been denied preventive and early intervention efforts that might have guided them toward other paths. As young children they are denied health care, nutritional help, and other supports critical to their social and emotional development. Early school failure contributes to their hopelessness about the future. Special education programs often ignore the needs of middle-school students, and there are few opportunities for young people to get the guidance of supportive individuals. Twenty-one percent of the juveniles arrested in the District in 1990 were not even attending school, and, according to the District's Office of Criminal Justice Plans and Analysis, 53 percent of the offenders currently serving sentences in District correctional facilities did not complete high school. A reduction in crimes can occur only through significant structural changes in the city that allow all children the opportunity to succeed.

## Children in Inappropriate and Overly Restrictive Settings

The District of Columbia currently faces a severe shortage of appropriate placements for children in need of out-of-home care. As a result the city spends tens of millions of dollars for overly restrictive group care settings, including residential treatment centers and institutions. That money could be invested better in supporting an array of community-based services, including foster family homes. Children with serious emotional problems appear most at risk of being placed inappropriately, often in distant states. Youths who are committed to the Youth Services Administration by the court for delinquent offenses are detained in institutions at a rate several times greater than in almost every state.

### *Lack of support for foster homes*

Foster parents, the mainstay of the foster care system, are diminishing in numbers. Those who remain are not getting critical services and supports. In 1989 about 800 children entered foster care, but in the three previous years only 70 foster homes were opened in the city. Although the number of children entering care dropped between 1989 and 1990, the number of children leaving care decreased by 30 percent. The demand on the system continues as the total number of children in care increased 8.8 percent over the year.

The increasing numbers of very young children entering care raise special concerns. Almost one-quarter (24.8 percent) of the children entering care in the first three months of 1991 were infants; 45.2 were two years old or younger. Such increases have important implications for the types of placements needed, as well as the long-range costs to the city of paying for the care of very young children for up to 18 years if permanent adoptive families are not found for the children who cannot be returned home.

Shortages of foster parents have resulted in severe overcrowding. It is not unusual for foster parents to be asked to care for additional children even if it means exceeding allowable limits in their homes. Discovery in the case of *LaShawn A. v. Dixon* – a class action lawsuit originally brought by the American Civil Liberties Union Children's Rights Project against former mayor Marion Barry and other city officials on behalf of children in foster care – revealed that 40 percent of traditional foster family homes exceed their licensed capacity and that such overplacements put children at risk.

The recruitment of new homes is hampered by a lack of funding. As of July 1990 only two part-time persons were involved in recruiting foster and adoptive parents. Reimbursement rates also are inadequate. Foster family care rates in the District vary by the age of the child and currently range from a base rate of $308 and $321 a month for children younger and older than 12, respectively, to $521 and $534 for children with multiple disabilities. These inadequate rates compare unfavorably with base rates for foster family care of $560 and $575 in neighboring Prince George's County, Maryland, or even with the cost of boarding a large dog at a District kennel for a month at $450. The rates contrast dramatically with the $460 *a day* it costs to keep a "boarder baby" no longer in need of medical care in the pediatric ward at Greater Southeast Community Hospital.

Even more critical to foster parents than reimbursement levels, though, is the lack of access to medical care and other special services the children need. Although the District seeks to offer help with day care costs, there are few opportunities for respite from the full-time demands of a medically fragile infant. Too frequently no efforts are made to match a child's needs with the services available. The Rivlin Commission documented the District's failure to train foster parents to care for children with disabilities.

The city operates few therapeutic foster family homes with specialized training and supports for the caretakers, despite its estimates that at least 50 percent of the children have special physical, mental, or emotional needs. Therapeutic foster homes, such as those operated by FLOC (For Love of Children) under contract with the District, have demonstrated not only the help such programs offer children but the cost-effectiveness of such approaches, as well.

One of the tragic outcomes of the shortage of specialized foster homes is the "boarder baby" phenomenon. Infants who are medically ready for discharge linger in hospital wards for an average of four months, but some for as long as nine months, without ever going outside in the sunshine or fresh air. As of June 1991 there were nine boarder babies in hospitals and another eight infants in a group care facility opened to care for the children who had been lingering in the hospitals. Many of the infants wait for foster homes; others wait for relatives who will need help for their special needs. For those with AIDS or HIV infection, small group care settings, such as Grandma's House and Grandpa's House operated by TERRIFIC, Inc. (and partially funded by the city's Department of Human Services), can offer them around-the-clock nursing care and extensive services when needed. The number of children who need such specialized group care, however, is very small.

### *Costly out-of-state placements*

Too often children are put in costly, overly restrictive placements, in which their needs are not met appropriately -- and at a cost that averages more than 10 times as much as foster home placements ($5,500 for a year of board and care payments -- not including the cost of social workers and other services -- compared with $60,000 for residential treatment per year). An analysis of the District's child welfare budget for out-of-home care costs conducted by the Center for the Study of Social Policy revealed a 370 percent growth in the cost of residential treatment, the most costly type of care, from 1985 to 1991.

Perhaps of greatest concern are the approximately 280 children, about 70 percent of whom have serious emotional problems, who are placed in residential facilities in distant states. Out-of-state placements occur at great fiscal cost to the city. These placements average $80,000 per child per episode and can run as high as $250,000 per year. The average duration of a placement is about 18 months, with some children staying two or three years or longer. The majority of the children have been committed to CFSD as dependent children, but some are in the custody of the Youth Services Administration and others have been referred for special education placements by the D.C. public schools.

Out-of-state placements cause great emotional turmoil to the children and families involved. Frequently the facilities do not have the resources necessary to serve the children appropriately. It is difficult to monitor the care individual children receive, and programs seldom are reviewed for their cultural competence and sensitivity, particularly important since the vast majority of children placed out of state are black. Children placed out of state are deprived of important connections to family and community. It is difficult for families to visit, and family therapy is impossible. Families are not assisted in preparing for children's return. Families' dysfunctional patterns often remain unchanged. As a result, even children who do improve while in residential care often lose those gains when returning to home and community.

Out-of-state placements have been of concern to advocates, providers, and policy makers in the city for more than a decade. Both *Bobby D. v. Barry* and *Jerry M. v. District of Columbia* -- class action suits brought against the city -- challenged the District's failure to place children with disabilities in the least restrictive settings appropriate to their special needs.

Over the past several years, the Commission on Mental Health's Children and Youth Services Administration (CYSA) has taken the lead in an effort to bring some children back from out of state. The Road Home Project, initially begun with funding from the Robert Wood Johnson Foundation, proposes to return children from out-of-state care and divert children referred for out-of-state care to less restrictive community-based care settings. Its efforts focus on children with the most severe diagnoses who require the attention of multiple agencies.

- CYSA reviews weekly the cases of all children from the child welfare, juvenile justice, and education systems who are referred for residential treatment. Funding authority for the residential placement of these children, the vast majority of whom have serious emotional problems, was transferred to CYSA in the FY 1991 budget.

- CYSA has implemented the ACCESS Central Intake Unit, which functions as the single entry point into nonresidential services for children with serious emotional problems. A multidisciplinary team representing CYSA, the child welfare and juvenile justice agencies, the school system, and the courts reviews children's cases weekly. The ACCESS Unit allows help to be provided directly to youths with little delay and red tape when resources are available.

- An automated data system also has been developed to track children in residential care, including those in out-of-state placements, and to ensure that each child has an individual service plan. Medicaid-eligible children also are reviewed regularly.

Despite these important steps, too many children continue to be sent out of state. A full continuum of alternative services in the city has not been established yet. The number of in-city slots is growing, but slowly

### Class Action Lawsuits

***Bobby D. v. Barry***: Filed in 1977, ***Bobby D.*** challenged the failure of the D.C. Department of Human Services to provide noninstitutional placements and support services for some children in its care. The class consisted of more than 400 children with mental, physical, and emotional disabilities who had been adjudicated neglected or dependent, many of whom were still in hospital settings years after physicians had called for their discharge. A 1980 consent decree sought to address directly many of the barriers to appropriate placements and services and to move the children into permanent placements. The plaintiffs continue to monitor semiannually the status of youths remaining in care.

***Jerry M. v. District of Columbia***: In 1985 the ***Jerry M.*** suit was filed on behalf of youths who were incarcerated in juvenile detention institutions operated by the Youth Services Administration in the D.C. Department of Human Services. The suit challenged the care and treatment of the youths in the facilities and sought to reduce the institutional population. In a July 1986 consent decree, city officials agreed to reduce the number of youths incarcerated and to improve the health, educational, vocational, and recreational services provided to youths in the institutions. The city also agreed and with some resistance. For example, despite repeated attempts since 1987 to open a 24-bed residential treatment center in the former Hurt Home in Georgetown, no beds exist. Community opposition, congressional action, and court decrees have delayed its opening. The FY 1991 District of Columbia Appropriations bill included language prohibiting the city from occupying the Hurt Home for residential or day treatment purposes until a final decision was rendered by the District of Columbia Court of Appeals in *Speyer v. Barry*. And the appeals court opinion, issued on March 29, 1991, now requires the city to meet additional requirements before opening the home.

### *Institutional care harms youths*

The trend toward overly restrictive care also is evident in the juvenile justice system. Almost two-thirds of the approximately 500 youths

to improve staffing, treatment planning, and disciplinary procedures. A subsequent court order held the District in contempt for not complying with the earlier agreement and required the city to establish a range of community-based programs.

***LaShawn A. v. Dixon***: In June 1989 *LaShawn A.* was filed on behalf of nearly 2,200 children in foster care under the supervision of D.C. Department of Human Services and the thousands of children who have been abused or neglected in the city. The suit charged then-mayor Marion Barry and other city officials with violating federal child welfare statutes, their own laws, and the rights assured these children under the U.S. Constitution. The city was charged with failing to initiate timely investigation of abuse and neglect, to prevent unnecessary foster care, to plan for and review appropriately the care children receive, and to move children into permanent settings in a timely fashion. Following an early 1991 trial, the U.S. District Court found in April 1991 that the District had deprived the children of their constitutionally protected rights. As of early September 1991, a final order for relief had not been entered. However, a proposed final order, which detailed specific reforms and a process for ensuring their implementation, had been submitted jointly to the court by the District's Department of Human Services and the American Civil Liberties Union, which represents the class of children in the case.

committed to the Youth Services Administration each year are placed in one of the District's juvenile institutions: the Receiving Home, a 38-bed locked coed facility in Northeast; Oak Hill, a maximum security 150-bed male facility in Laurel, Maryland; or Cedar Knoll, also in Laurel, a 144-bed male facility with no perimeter fence but some secure buildings. Some youths detained while awaiting trial also are housed in the facilities, usually the Receiving Home or Cedar Knoll. Although secure institutional care may be necessary for some chronic and violent young offenders, evidence from other jurisdictions makes clear that the most appropriate way to rehabilitate many delinquent youths is through small community-based programs.

The number of incarcerated committed youths in the District nearly doubled between 1987 and 1990, despite decreases in petitions and juvenile commitments, and despite a court order in *Jerry M.* requiring decreased reliance on institutions. Cedar Knoll, for example, which District officials originally had agreed to close by December 1987, instead saw an almost 50 percent increase in its average daily population between FY 1987 and FY 1990 (up from 109 to 163).

For the most part, the alternative therapeutic foster and group homes and intensive nonresidential services envisioned by *Jerry M.* have not been developed. Despite a study by the Center for the Study of Youth Policy showing that 58 percent of committed incarcerated youths in the District were appropriate for community-based placements, the majority of juvenile offenders still find themselves in institutions:

**Committed Youths**

(A one-day census)

| Type of facility | 1987 | 1990 | *Jerry M.* targets |
|---|---|---|---|
| Institutions | 121 | 227 | 60 |
| Residential treatment | 108 | 127 | 60 |
| Group homes | 36 | 34 | 93 |
| Foster homes | 11 | 9 | 40 |
| Nonresidential | 60 | 0 | 155 |

It's a Catch-22 situation. YSA administrators say they cannot reduce the number of youths in institutions because admissions are driven by the court. Judges, meanwhile, say that their dispositional decisions are a direct consequence of the lack of community-based programs and weaknesses of aftercare services. Judges consistently indicate that if YSA operated more group and foster homes, they would commit fewer youths to institutions.

Millions of dollars have been spent to maintain youths at Oak Hill, Cedar Knoll, and the Receiving Home while little has been done to establish the neighborhood-based services called for in *Jerry M.* that would reduce the institutional population. The cost of housing one youth for one year at Oak Hill is $40,000, far greater than the cost of nonresidential, vocational counseling, or entrepreneurial programs that average about $12,000 per youth, per year, or the costs of therapeutic foster homes that run about $15,000 per youth, per year. The successful High Intensity Supervision (HITS) Program operated by the Court Social Services Division assisted almost 200 youths in 1990 through an intensive program of counseling, community services, and group meetings after school. The program costs only about $20.19 per day, per child, one-sixth the daily rate at Oak Hill. It is simply unacceptable to have more than 350 youths in institutions when many of them could be served more effectively in community programs at far less cost.

## Lack of Interagency Collaboration Hampers Potential Improvements

For many years in the District of Columbia there was virtually no communication, much less collaboration, among the multiple agencies in the city charged with meeting the needs of vulnerable children and adolescents (despite their serving children with similar needs and confronting similar gaps in service). More recently, agencies have recognized the need for better cooperation and collaboration. The Road Home Project served as a useful catalyst to get started. The Interagency Board, which includes a range of public and private child-serving agencies, also has met regularly over the past two years to identify service gaps, develop improved service approaches for children with multiple needs, and recommend improvements in policy and practice. More needs to be done now to establish permanently such interagency efforts and to expand joint funding, training, case resolution, and service delivery initiatives. Without such efforts, children and families will not benefit.

Some steps already taken that need to be expanded include:

- In February 1990 a multidisciplinary team, consisting of a psychiatrist, psychologist, and social worker from the community mental health clinics, began providing mental health services at several elementary schools and a junior high school for children referred by school counselors. More staff are needed to expand the program.
- A mobile mental health response team developed by CYSA goes to schools, neighborhoods, or other sites when emergencies such as fires, shootings, or suicides occur. The team also has provided consultation on early childhood for two child care centers.
- CYSA also has established an emergency response team to work with youth leaders from the Department of Recreation to run groups for children and young adults at one of the city's public housing projects that is besieged by drugs and crime. Groups on substance abuse, self-esteem, and community pride are being conducted.
- A mobile mental health unit, originally funded with some help from the federal Stewart B. McKinney Homeless Assistance Act and now funded totally by CYSA, provides crisis intervention and short-term treatment for families in homeless shelters in the city.
- The Interagency Youth Project (IYP), operated by the Office of Criminal Justice Plans and Analysis, purchases services for 30 youths on probation and 30 youths committed to YSA who live at home or in group homes. IYP sponsors interagency treatment meetings in which individualized service packages using a variety of vendors are designed. Efforts by the probation department to help other youths also are augmented by home-based, education, mental health, and employment services and a new school-to-work transition program.

In other cases, collaborative efforts have been initiated but never brought to fruition. For example, regulations for the Youth Residential Facilities Licensure Act drafted in 1987 by a multidisciplinary Advisory Task Force representing a broad cross-section of provider and community organizations in the city have not been implemented yet, or even published for public comment. Yet these regulations, at least as submitted to the Director of the Department of Human Services in June 1987, would strengthen significantly protections and the quality of programming for youths in various residential settings, both in and out of state, regardless of their labels or the system of care to which they are attached. The lack of such standards negatively affects the quality of care provided by foster family homes and residential facilities, according to CFSD staff. Monitoring efforts undertaken by individual agencies frequently carry with them no real authority to insist that improvements are made when the quality of care is questioned.

In other areas collaboration has yet to occur in any significant way. For example, little coordination exists among CFSD, the Alcohol, Drug and Substance Abuse Administration, or the Office of Maternal and Child Health to address the myriad problems related to substance abuse. Similarly, child protective service workers have little knowledge or training in assessing chemical dependency problems or avenues for appropriate treatment.

There also have been no joint efforts between CFSD and the Department of Public and Assisted Housing to reduce the number of families experiencing initial or prolonged separations because of homelessness or inadequate housing. The District has not enacted initiatives to allow foster care dollars to be used for housing stipends to prevent unnecessary placements, nor is a housing ombudsman in place in CFSD to assist families with their housing problems.

Expanded efforts also are needed between the executive agencies and the courts – including joint training regarding attitudes and skills – to ensure that cases will be processed in a timely fashion and appropriate dispositions made.

Finally, there has not been the leadership or commitment necessary at the highest levels to build upon interagency initiatives that have been undertaken or to increase community support for innovative programs and the comprehensive systems of care needed in the city.

### Chronic Staff Shortages and Inadequate Staff Supports

Front-line staff members who seek to help vulnerable children and their families are left with overwhelming responsibilities and few supports. Problems in recruitment and retention as well as inadequate training and support seriously jeopardize the quality of care and services provided.

Chronic staff shortages have persisted for years, particularly within CFSD. For example, abuse and neglect reports increased 28 percent between 1984 and 1988, yet during that time CFSD had a net increase of only two workers.

In its *Fiscal Year 1989 Annual Report on the Implementation of the Prevention of Child Abuse and Neglect Act of 1977*, the division acknowledged that severe staff shortages and the absence of leadership affected its ability to provide "even a minimum level of services and care to neglected and abused children and their families." By its own admissions, the division was unable to comply with legal mandates; to monitor children and families at risk; or to train, manage, and support properly staff members who were there. In September 1989, for example, caseloads in the Continuing Services Branch averaged 56 families and 125 children per worker. These caseloads were double the division's own goals established in 1987, and far in excess of the levels recommended by the Child Welfare League of America (CWLA). CWLA's recently developed national standards recommend caseloads of 12 cases per month, per worker, in intake and investigation, and 17 families per worker for ongoing cases. Recommended levels of foster care caseloads range from 20 to 30 children per worker.

In FY 1991 CFSD requested an increase of $1.8 million and 75 full-time positions to address its rising child abuse and neglect caseload. Despite authorization to fill these vacancies and to hire 45 additional social workers and 17 supervisors, severe staff shortages continue. New hires barely keep up with resignations. As of April 1991 only 48 of the 75 new positions had been filled, and the CFSD still had 80 social worker vacancies. Overall CFSD had 132 filled and 107 vacant positions. Trial testimony from social workers in *LaShawn A. v. Dixon* cited how caseloads as high as 251 children leave many children at risk of living with abuse and neglect or languishing in foster care. Social workers race from crisis to crisis with little opportunity to plan appropriately or review regularly the children they are charged with protecting.

Large caseloads and little support for workers in turn make staff recruiting difficult. Concerns about safety and security jeopardize the division's ability to hire. Starting salaries are not competitive with neighboring jurisdictions. Until early 1991 most positions offered were only term appointments, not to exceed two to four years, so permanent job security was lacking. Promotional opportunities also are limited. Smaller caseloads within other administrations of the department result in CFSD losing workers to other administrations.

The staff shortages are exacerbated by the gross lack of support staff. Supervisors must carry caseloads and cannot offer line staff members the administrative support, training, and other help they need. Other supports also are lacking. For example, despite its caseload of increasingly troubled families, CFSD has no psychiatric consultations for the children it serves, and has had none since 1982. Nor is there any regular consultation to help staff members cope with the chemical dependency problems that are plaguing the families they see. Assistance with legal responsibilities also are lacking. Social workers get delayed with paper work and transportation activities that could be done more efficiently by case aides.

Staff members also lack ongoing training and supports that are critical for them to carry out their responsibilities adequately. Until recently, little formal training has been available to CFSD workers or supervisors. The department has failed to take advantage of the 75 percent federal reimbursement available for pre-service, in-service, and specialized training.

The care children receive and its timely delivery also are threatened by staff shortages in the D.C. Corporation Counsel's Office. That office, which is charged with petitioning both abuse and neglect and delinquency cases, has been operating at far less than its authorized strength. Yet abuse and neglect petitions more than doubled between 1985 and 1989, and increased 50.6 percent between 1988 and 1989.

Chronic staff shortages also have hampered the Youth Services Administration's progress in complying with the *Jerry M.* decrees. Staff shortages in the institutions impair the level of supervision and programming that can be provided. Excessive overtime necessitated by these staff shortages and overcrowding results in overworked staff with little time or capacity to respond to the needs of individual young people. The Rivlin Commission reported that in FY 1989, 25.1 percent of the funds requested for YSA's salaries were for overtime, and recommended that vacancies be filled and 75 new employees be hired. As a result of staff shortages, the educational and other treatment needs of detained youths go unmet; aftercare services fall far short of what are needed.

## Opportunities for Reform Have Been Ignored

Tragically, District officials too often have failed to do what they know needs to be done to strengthen these systems of care, to offer support to fragile families and children, and to offer hope to these troubled children and adolescents. Just in the past five years detailed plans to reform all three of these child-serving systems have been prepared. In mental health and juvenile justice, blueprints for reform have existed since 1986. More recently, recommendations for reform presented to the court in *LaShawn A. v. Dixon* by the Center for the Study of Social Policy outline a number of specific action steps that could improve the city's child welfare system significantly.

The immediate challenge is to ensure that steps are taken to provide the leadership, commitment, and management capacity necessary to implement the recommendations embodied in these various blueprints for reform.

### Mental Health Implementation Plan

The Mental Health System Implementation Plan was developed as part of the Mental Health Reorganization Act of 1986 that resulted in the establishment of a separate Commission on Mental Health in the District and the establishment of a Children and Youth Services Administration within it. The plan promised the development of a full continuum of mental health services for children, youths, and their families that was family-centered, emphasized early intervention and outreach, provided case management to ensure individualized treatment and continuity of care, ensured placements in the least restrictive settings appropriate to the special needs of the children served, and emphasized coordination and cooperative ventures with the other child-serving agencies. An identifiable children's budget and system-wide quality assurance program also were part of the planned improvements. The Implementation Plan projected that by 1991, 6,700 children and youths would be served, with fewer than 100 needing intensive residential treatment services in out-of-state facilities. The plan and the comprehensive system of care outlined therein were applauded nationally. Unfortunately, however, as this chapter reveals, numerous systemic barriers and administrative roadblocks have prevented many of the promises in the plan from being realized.

### The Consent Decree and Orders in *Jerry M.*

The abuses and deficiencies in the District's juvenile justice system were the subject of class action litigation. *Jerry M. v. District of Columbia* was brought by the Public Defender Service and the ACLU Prison Project in March 1985. The Youth Services Administration and other public defendants in *Jerry M.*, in an attempt to address these abuses, voluntarily agreed in 1986 to provide a range of services to the young people they were charged to serve. The Consent Decree in *Jerry M.* required a reduction in the incarcerated population and a substantial upgrading of educational, vocational, medical, and recreation programs, and disciplinary procedures and treatment planning at the Receiving Home, Cedar Knoll, and Oak Hill to ensure that they complied with national standards. Subsequent orders by the court in the case have sought to achieve compliance with the Consent Decree. Memorandum Order B, for example, issued in May 1988, required the establishment of a range of community-based services such as programs for substance-abusing families, vocational services, and therapeutic foster and group homes. Together, the *Jerry M.* Consent Decree and Order B provide a comprehensive framework for reform of services for all detained and committed delinquents in the District. Compliance with these decrees, however, has fallen far short of the intended goals. Not only do children suffer, but the District has been charged hundreds of thousands of dollars in fines for failure to comply with court mandates.

### Center for the Study of Social Policy's 1990 Review of the Child Welfare System and Relief in *LaShawn A.*

An analysis of the problems facing the District's child welfare system prepared by the Center for the Study of Social Policy for the trial in *LaShawn A. v. Dixon* identified many of the failures in the system described in this chapter. The Center's report, *Children and Family Services in the District of Columbia*, details 25 specific recommendations for action that together outline a "comprehensive effort to improve outcomes for vulnerable families and children in the District." These recommendations address specific steps that must be taken to improve case planning and the delivery of improved services and supports to strengthen families, serve children who must be placed in care, and to enhance adoption opportunities for children for whom adoption is the appropriate plan. They recommend improvements in staffing, training, internal monitoring, and data collection that will help ensure adequate and appropriate attention of children's needs. The report also suggests how the city, by better using available federal funds, can secure additional resources needed to address service gaps in city services. It highlights the need for visible high-level leadership and commitment to address problems in the delivery, administration, and financing of child welfare services.

The U.S. District Court's April 18, 1991, opinion in *LaShawn A.* reiterated many of the findings cited in the Center's report in holding the District's child welfare agency liable for violating the constitutional rights of the children in its custody. The judge's opinion and order provided an opportunity for District officials to begin to address fundamental systemic problems that have plagued the child welfare system for years, undercut the best efforts of the system's cadre of caring workers, and jeopardized the care thousands of children received.

Although a final order had not been entered in the case by early September 1991, it is expected that the Department of Human Services and the attorneys for the children in the class soon will agree to a proposed order that will address the reforms that are needed and a process for ensuring that the reforms are implemented over the next two to three years. The Center for the Study of Social Policy likely will be designated as the monitor to develop an implementation plan and to ensure effective and prompt implementation of the order.

### Budget and Management Problems

Reform efforts across systems serving abused and neglected children, those with serious emotional problems, and youths who are in trouble with the law have been hampered by various budget problems: hiring and spending freezes, contracting problems, budgeting shortfalls, and the reprogramming of funds.

Hiring and spending freezes have undercut the Children and Youth Services Administration's ability to take the steps necessary to implement the comprehensive system of services outlined in the 1986 Mental Health Implementation Plan.

A review of budget requests for CYSA since FY 1988, the first year of a separate children's mental health budget in the District, creates the impression that CYSA had received the support necessary to implement the 1986 plan. Upon a closer look, however, one sees that what actually was spent each year for children's mental health, at least in FY 1988 and 1989, barely exceeded half of the amount originally budgeted, and the trend continued in 1990.

Although the FY 1988 budget included $16.9 million, a significant increase over the previous year's budget of $10 million, only $10.9 million actually was spent. Hiring freezes and contracting problems delayed implementation of planned activities, and a portion of the funds originally budgeted was transferred to Adult Services within the Commission on Mental Health to offset a deficit there. Program improvements had to be delayed.

The agency then became locked into an underspending syndrome that undercut its ability to serve children in need appropriately. Delays in program start-up continued, caused by the previous fiscal years' hiring freezes; moratoriums on staffing, procurement, and equipment purchases; changes in contracting; and overspending in the adult system.

In the Child and Family Services Division the budget figures initially established each year always have been too low to cover basic costs, much less any program expansions. Until 1990 no steps had been taken in the Department of Human Services to bring the CFSD budget in line with spending. The failure to budget adequately for foster care, for example, often required mid-year adjustments. Funds were borrowed from other programs, sometimes without even the other programs' knowledge, to make up for foster care short-falls that had been predictable from the beginning of the year.

Projected expenditures for staffing were based only on on-board staff, and did not reflect even the resources necessary to provide pay increases already approved for these staff members. The deficit was worsened by the fact that the Commission on Social Services did not budget for vacant positions. On more than one occasion, the Mayor's Office or the City Council, thinking vacant positions were budgeted for, cut these same unfunded positions again in an attempt to come up with additional resources.

Recent budget requests for CFSD have failed to account for the increases in child abuse and neglect reports, the growth in the foster care caseloads, or the serious shortages of line staff and supervisory staff in the division. Although some progress appears to have been made in addressing the shortfall in foster care funds to cover existing children in placements, children will not benefit if such increases are obtained by eliminating funding intended to fill staff vacancies, as has been proposed for FY 1992.

Budget shortfalls in the Youth Services Administration have been in part responsible for the failure to implement some of the alternatives to institutional care set forth in the *Jerry M.* decree. The congressionally approved budget levels for FY 1989 through 1991 have left virtually no room for new initiatives. Ironically, some of the only initiatives under way are those that have been funded with the fines paid to the court by the Department of Human Services for its failure to comply with *Jerry M.*

## Missed Opportunities for Federal Funding

The programmatic deficiencies that jeopardize the futures of thousands of children in the city also are in part the result of the District's failure to claim fully millions of dollars in federal funds. Several studies in the past, and more recently the reports prepared by the Rivlin Commission and the Center for the Study of Social Policy, have documented the city's inadequate claiming of federal funds under the federal Foster Care and Adoption Programs authorized under Title IV-E of the Social Security Act and the federal Medicaid program. Enhanced funding opportunities for children with disabilities also are available now under the federally funded Supplemental Security Income (SSI) program.

### *Title IV-E*

According to estimates by the Center for the Study of Social Policy, the District could obtain at least an additional $14 million a year in federal funds under the Title IV-E Program if appropriate policies and procedures were implemented. Under the Title IV-E Foster Care Program, the District is eligible to receive federal reimbursement at varying matching rates for: the room and board cost of maintaining certain eligible children in out-of-home care (50 percent); administrative costs related to the care of these children, which include general administration as well as a range of pre-placement and child placement related costs (50 percent); and the costs of training for public agency staff, foster and adoptive parents, and staff of child care facilities caring for Title IV-E children (75 percent). Because Title IV-E is an open-ended entitlement program, the federal government will reimburse the District on an unlimited basis for as many eligible children and as many allowable activities in the areas of administration and training as it claims under Title IV-E.

To date, however, the District has not taken full or appropriate advantage of funding opportunities in any of these areas. Looking only at children in care who are wards of CFSD, for example, the District is claiming federal reimbursement under IV-E for only about one-quarter of them, when it has been estimated that about 60 percent of the children should be able to qualify. In addition, it is likely that reimbursement could be obtained for some of the children committed to YSA for care. As a result, the city has lost millions of dollars in federal funds.

The District also has been eligible under Title IV-E for funds to help youths in foster care who are 16 years old and older make a successful transition to independent living when they leave care. However, the Office of the Inspector General in the federal Department of Health and Human Services found that the District had spent only $12,000 of the $635,000 available to it through September 30, 1987, and therefore had forfeited more than $600,000 in federal funds that was available without even the requirement of a local match.

The failure to maximize federal funds for room and board costs, and other eligible expenditures, is a result of multiple problems: the lack of an appropriate management information system to track the status of children in care and relevant expenditures, the lack of training for staff about claiming procedures and their relevance to care, inadequate cost allocation procedures, and the inappropriate application of case planning and review procedures.

### *Medicaid*

Enhanced efforts to claim untapped federal funds under the Medicaid program also would go far to ensure that children's needs were better served. The city can claim 50 percent federal reimbursement under the Medicaid program for basic medical care for many of its wards, and also can claim the same match for residential treatment services for some of the children and many of the other specialized services that children with serious emotional disturbances and other special needs require.

The Children and Youth Services Administration has made efforts recently to ensure that all children with serious emotional problems who are eligible for Medicaid are enrolled. Enhanced steps also have been taken to ensure that eligible children receiving outpatient services and care in residential programs accredited by the Joint Commission on the Accreditation of Health Care Organizations are having their care reimbursed by the federal government. Similar reviews by CFSD and YSA also are needed.

The city could take advantage of numerous service arrangements under Medicaid to help provide critical services to children in its care. Home-based services for children, for example, are reimbursable as personal care and rehabilitation services. Case management now is a service mandate under Medicaid's EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program. Much of the cost of day treatment, special education-related clinic services, and therapeutic nursery programs for children with serious emotional problems are reimbursable as day clinic costs.

The District must immediately take steps to overhaul its Medicaid coverage limits and should ensure that all Medicaid-eligible children with emotional disabilities, and others who are wards, receive a comprehensive EPSDT exam so that the specialized care they need can be reimbursed under Medicaid. As a result of 1989 changes in the federal Medicaid program, the District now must provide to all Medicaid-enrolled children younger than 21 who are participating in EPSDT coverage for all medically necessary care and services needed to treat or ameliorate identified physical or mental disabilities and illnesses.

### *SSI*

While the District is reviewing children for Medicaid eligibility and ensuring that they have EPSDT screens, the city also should determine if the children are eligible to receive benefits under SSI. SSI provides monthly federal payments (that the District supplements) to children who are blind or have physical, mental, or emotional disabilities, and whose family income and resources are below specified levels. New federal regulations issued by the Social Security Administration in February 1991 broaden the eligibility criteria for childhood disabilities for SSI for poor children younger than 18. These regulations came one year after the U.S. Supreme Court in *Sullivan v. Zebley* found that the disability eligibility criteria that the Social Security Administration had been using were too restrictive and excluded many children with severe disabilities.

Child welfare systems in a number of states now are reviewing their caseloads to determine whether children are eligible for these federal payments, and in some cases also eligible for back payments.

As steps are taken to maximize federal funds under Title IV-E, Medicaid, and SSI, it is critical that any federal funds that are remitted to the District be committed exclusively to the improvement and expansion of home- and community-based services for vulnerable children and families. Without such assurances, children will not benefit.

## Recommendations

The District of Columbia cannot afford not to take the steps necessary to improve its systems of care for vulnerable children and adolescents and their families. With this group of children, the question is not whether to invest in their behalf, but when and how. As the cases of Tina, Mary, and Lemoyne demonstrate, without help the needs of these young people will not disappear, but rather they will intensify and so will the costs to society as children move from one child-serving system to another, or from the youth system to the adult mental health or criminal justice systems.

What is needed now is the leadership and commitment to take the necessary steps to improve the lives of these young people. There is help out there to do the job. Up-front investments now will result in the avoidance of future costs. Better use of federal dollars will enable the city to claim, at worst, a second dollar for every dollar it invests. And then, by reinvesting newly tapped federal funds into prevention, even greater savings can be achieved.

In seeking to address more adequately the needs of abused and neglected children, those with serious emotional problems, and young people who get in trouble with the law, the following steps must be taken.

***Implement prior plans for comprehensive services and reform of fragmented systems.***

- The mayor must make an immediate commitment to expand interagency initiatives, increase community support, and strengthen the comprehensive systems of care needed in the city. As part of such a commitment, the mayor must designate a person responsible for developing a workplan, including a timetable, for fully implementing, within the next three years, all of the reform proposals included in the Final Order in *LaShawn v. Dixon*, the 1986 Mental Health Implementation Plan, and the Consent Decree and Memorandum Order B in *Jerry M. v. District of Columbia*. The mayor's FY 1993 budget should reflect the funding increases and redirections necessary to finance the first year of the implementation effort.

*Fully claim federal funds.*

- The Director of the Department of Human Services immediately should take steps to ensure that the department is using all federal funds to which it is entitled under Medicaid; the Title IV-E Foster Care, Adoption Assistance, and Independent Living programs; and the Supplemental Security Income Program, as well as other federal programs. It is critical that federal dollars received and any dollars ultimately saved through the avoidance of out-of-home care be reinvested in prevention, early intervention, family preservation, and community-based programs.

*Fill staff vacancies.*

- Representatives from higher education, the business community, public and private service providers, line staff, children's advocates, and religious leaders, as well as national experts, should be convened to begin filling the staff vacancies throughout the child welfare, mental health, and juvenile justice systems. Little will improve unless vacant positions are filled. Salaries and conditions for employment must be equivalent to those in neighboring jurisdictions. Enhanced pre-service and in-service training must be provided.

*Invest in prevention.*

- A family preservation service unit should be established to act as a gatekeeper for children at risk of placement in the child welfare, mental health, and juvenile justice systems. The experience of other cities can be drawn upon in developing an intensive family-based crisis intervention program that can accept referrals from all three systems. The community-based services necessary to supplement the intensive family-based services also must be established. Family preservation programs are not only beneficial to families and young people but are cost-effective, as well.

*Expand quality out-of-home care settings.*

- The District should expand the pool of quality out-of-home care settings available to children in the city. The regulations developed by the 1987 Mayor's Advisory Task Force to Develop Licensure Standards for Youth Residential Facilities to ensure basic protections and quality programming in residential placements should be published immediately for public comment and finalized.

- Public and private agencies should join to develop a network of therapeutic foster family homes that are compensated and supported adequately to meet the special physical and emotional needs of children whose families cannot be preserved. Private agencies should play a major role in the design of the network and in the recruitment, selection, training, and support of the foster parents. Broad community support is needed to enable the placement of therapeutic community-based programs throughout the city.

*Develop neighborhood-based services.*

- The District should develop cross-system, neighborhood-based initiatives that addresses the multiple needs of children and families involved or at risk of involvement in the child welfare, mental health, and juvenile justice systems. Private providers, religious organizations, civic associations, and other community groups should be enlisted to help in the design and delivery of services that help prevent children and youths from entering out-of-home care, work with families if placement is necessary, and provide support for families after children return.

# Family Income

Nearly one in three children in the District is poor, and the child poverty rate has increased substantially since 1980. Although children make up only one-fifth of the total city population, one-third of all poor District residents in 1986 were children younger than 18.

The child poverty rate is especially appalling in light of the District's comparatively high median income – $38,562 for a family of four in FY 1991, higher than the median incomes of four-fifths of all states. While many District residents flourish, poor children often live in a world apart, missing any benefit of the District's comparative affluence.

## Why District Children Are Poor

### Low Earnings

Many workers earn too little to support families and lack the skills or training to earn more. For many workers in the District, work opportunities are part time, part-year, or pay so little that work alone (at the minimum wage of $4.25 per hour) does not lift them and their families out of poverty. According to the city's 1988 report, *Who's Poor in the District of Columbia*, nearly half (46 percent) of poor working-age adults in the District have jobs.

Job prospects are limited for workers without higher level skills. The Greater Washington Research Center reports that only 30 percent of all area jobs are open to applicants without high school diplomas. The starting wages for such jobs, however, even when full time, are barely enough to lift families above the poverty line. But only three out of four of the jobs are full time, and only one in three is both full time and lasts for a year or more.

### Single-Parent Families

Many children live in single-parent families. In 1980, the most recent recent year for which data are available, 58 percent of District children lived in single-parent (and in most cases female-headed) families -- more than double the national average of 23 percent. About half of all children living in female-headed families are poor.

Lower wages for women, the high cost of child care, and the absence of any earnings from a second adult all contribute to a higher poverty rate for female-headed families.

### Inadequate Help

The District's safety net fails many needy families and provides far too little help to others. In theory, the District has a safety net for poor children -- made up primarily of Aid to Families with Dependent Children (AFDC), food stamps, and child support -- that is designed to meet their most basic needs for food, shelter, medical care, and clothing. However, the District's policies in assisting poor families frequently fail to focus on cost-effective preventive investments, instead relying upon approaches that yield small savings in initial outlays but lead to more costly problems in the future.

Many children do not get the child support they need and get inadequate help from the District in pursuing it. Parents have a primary role in providing for the support of their children. Some cannot pay, or cannot pay enough, and in those cases government must step in to help the children. Sadly, some can pay, but will not. Nationally, about one-quarter of absent parents do not make any of their court-ordered child support payments, another quarter make only partial payments, and only half pay the full amount due.

Federal law requires state child support enforcement agencies to help families receiving AFDC, and those not receiving AFDC that ask for help, to establish paternity and to collect child support. Nationally, as well as in the District, the past performance of these agencies has been dismal. A recent "report card" by the Ways and Means Committee of the U.S. House of Representatives found that states in general (and the District in particular) averaged a "strong D" in providing child support services to needy families. New federal child support enforcement requirements enacted in 1984 and 1988 give states new tools for enforcement and require better performance by state child support enforcement agencies, offering new hope that children will benefit from child support.

Income support available through AFDC is another inadequate piece of the safety net. As of May 1991 the District's AFDC program, the primary way the District provides cash assistance for poor families with children, paid $409 per month to meet most of the needs of a three-person family, including housing, utilities, transportation, clothing, and food costs not covered by food stamps. This amount is about half the federal poverty guideline and falls far short of what many families need to make ends meet. Even taking into account the value of food stamps, the District AFDC grant brings families to only slightly below three-quarters of the 1990 federal poverty line.

Moreover, the District AFDC grant must stretch to meet housing costs far higher than those faced by families in neighboring metropolitan areas. According to the U.S. Department of Housing and Urban Development (HUD), the fair market rental value of a modest two-bedroom apartment in the District is $731 per month, compared with $450 per month in Richmond, Virginia, and $547 per month in Baltimore, Maryland.

## Holes in the District's Safety Net

### AFDC

Administered in the District by the Department of Human Services, AFDC is available to families in which children are deprived of the support of one parent because the parent is absent from the home, incapacitated, or deceased. It also is available to two-parent families in which the principal earner is either unemployed or underemployed.

Each state sets a standard of need that represents what a family needs for poverty-level subsistence. The standard is used to determine initial eligibility for AFDC. As of May 1991 the District's need standard for a family of three was $712 per month – 81 percent of federal poverty guidelines for a family of that size. Thus, many poor families cannot qualify for AFDC benefits in the District.

Staff shortages in the District's AFDC office also thwart effective services for poor families. With more than 150 vacancies in the Income Maintenance Administration, it is difficult for workers to comply with basic federal eligibility determination and case processing timelines. It is even more difficult to provide the individualized case management and support many families and individuals need.

The adequacy of District AFDC benefits steadily decreased for many years as grant increases failed to keep pace with inflation. From 1970 to 1990 the value of the three-person AFDC grant fell by 36 percent in constant dollars. While the District has had an automatic cost of living adjustment for the past four years, the adjustment does not make up for the enormous ground lost in previous years. Moreover, recent District legislation has repealed this annual adjustment and rolled back benefit levels to the 1990 amounts (this means that a family of three, which would have been eligible for a $428 grant based on cost of living increases, will be eligible for a maximum of only $409). This repeal further erodes already inadequate benefits and heightens the prospect that the families will lose even more ground in the future.

The adequacy of AFDC benefits is threatened further by impending federal fiscal sanctions of more than $500,000, which will be assessed against the District's AFDC program as a penalty for past failure to comply with federal child support enforcement requirements. It is unclear how the District will absorb the cost of the penalty. Because it is assessed against the AFDC program, however, the penalty threatens to make AFDC recipients the victims of past failures of the child support program and the District government's failure to invest adequately in child support enforcement.

The adequacy of AFDC is jeopardized as well by a caseload that has increased sharply, from 47,000 people on AFDC in FY 1990, to 56,500 in June 1991, to an estimated caseload of almost 64,000 in FY 1992. States across the country are facing similar recession-driven caseload increases. The District is proposing to fund help for these newly poor AFDC families by redirecting $3.2 million from the General Public Assistance program and eliminating coverage under that program for adults unable to work because they have a short-term physical or mental disability, certainly an unacceptable trade-off.

### *AFDC and housing*

While the District's housing crisis cannot be solved through the AFDC program, the District has failed to take advantage of a number of opportunities to use AFDC as a means of ensuring that poor families do not become homeless.

The $731 per month fair market rental value of a modest two-bedroom apartment of a safe and sanitary nature is more than one-and-a-half times greater than the maximum AFDC grant provided to meet *all* of the needs of a family of three, including rent. As a result, many AFDC families live doubled up or tripled up. While some of these shared arrangements are healthy ones, others reflect desperate and often short-lived efforts to forestall homelessness.

The cost to the District of providing emergency shelter for families when their housing arrangements break down is staggering – more than $3,000 a month for room and board in some of the city's hotel shelters, or more than seven times the AFDC grant for a family of three. In addition, the emotional and physical costs to families that become homeless are devastating.

Increasing the basic AFDC grant and expediting approval of AFDC benefits for families on the verge of losing their housing would go a long way toward preventing homelessness. The District could exercise other options under the AFDC program to get additional federal help. For example, Connecticut and Massachusetts provide federally matched AFDC special needs grants to families with very high housing costs. Despite the high cost of its housing, the District does not provide such a special needs rent supplement.

A number of states use the AFDC special needs program to cover other expenses, such as fuel or utilities; repair of property, appliances, or furnishings; moving and storage expenses; fees or deposits; temporary shelter; and expenses caused by catastrophe or eviction (including back rent that will prevent eviction).

The District provides many of these services to families, both those that require AFDC and those that do not, through its federally matched Emergency Assistance program. Because of technical restrictions, however, the city also loses some federal matching funds by failing to provide help through the special needs programs.

### *AFDC training and education programs*

The federal Family Support Act of 1988 places renewed emphasis on employment, education, and training efforts (including help with child care) as a way of helping families leave the AFDC program. In-depth training and education programs are important, since many parents do not have the education or job skills to earn a wage that will enable them to support their family. While the District implemented the new Family Support Act provisions on April 1, 1990, it will take some time to assess effectiveness. Only 2,500 participants are expected in the District's Family Support Act Job Opportunities and Basic Skills (JOBS) program during each of its first two years of operation. About twice that number belong to the special groups targeted by the Family Support Act for employment and training services.

The District could provide AFDC parents with greater financial incentives to work but has not done so. For the fiscal year ending September 1988, only 2.9 percent of District AFDC households had earned income (compared with 8.4 percent nationally). Some states (for example, Tennessee and North Carolina) encourage families to work by calculating their AFDC grants in a way that allows them to keep more of their earned income without having their grants reduced.

The District has failed to take advantage of federal AFDC options that encourage AFDC children to become involved in employment and training activities. For example, although 47 states disregard all earned income of a student for six months per calendar year the District does not do so. The District also counts student income in determining whether a family is eligible for AFDC, an approach that obviously discourages students from working.

The District's failure to preserve work and training incentives for youths extends to other areas as well. Unlike all but four states, the District counts a child's earnings or stipends from participation in federally funded Job Training Partnership Act (JTPA) programs for AFDC purposes. The District also makes no provision for disregarding the income of a child working part time.

The District fails to take full advantage of the Family Support Act to build creative programs that help teen parents stay in school or return to school if they have dropped out. Of the 2,041 parents younger than 21 on AFDC in early 1991, only 215 teen mothers were enrolled in the District's JOBS program. At the time, 48 of these mothers were participating in a new and innovative project in Anacostia, where two school rooms have been renovated to simulate an office environment. Teen parents learn reading, math, typing, computer programming, and work skills by spending their entire school day in this supervised work simulation. They learn problem-solving skills necessary for work with the aid of interactive video. Such help is essential if they are to become self-sufficient and move off of AFDC.

Unfortunately, the JOBS program does not reach the vast majority of teen parents on the rolls. There are no workers with specific responsibility for teen parents, no systematic outreach, and no way to identify service needs or to link teen parents with the various educational services available.

The District could learn from other localities that are making exciting use of Family Support Act funds, combined with other resources, to shape comprehensive service programs that help teen parents stay in school. The San Diego Department of Social Services, for example, reallocated regular service workers to give them explicit, separate responsibility for AFDC teens. It has regular "cross-training" sessions with other organizations serving teen parents to identify local resources and to ensure that teens are linked with all available forms of assistance.

The program provides extensive child care counseling and support for on-site child care centers at local high schools. It also runs teen parent support groups at schools and provides counseling to help young parents with money planning, medical care, and other support needs.

In Portland, Oregon, the school district and welfare department together provide intensive re-entry services to teen parents who have been out of school. The two offices jointly fund efforts to support teen parents who return to school, helping with child care needs as well as providing such services as parenting education and child development training. Similar efforts could help the District better meet the needs of its teen parents.

### Food Stamps

Food stamps supplement the District's AFDC program. However, even the combination of food stamps and AFDC benefits in the District does not lift children out of poverty. The combined value of the maximum AFDC grant for a family of three and food stamp benefits ($633 per month) is only 72 percent of 1990 federal poverty guidelines.

Recently, there has been a large decline in the number of food stamp participants in the District. From 1985 to 1989 the average number of recipients fell by 19 percent – from 73,822 to 59,844 per month. District officials attribute this decline to changing federal eligibility requirements and smaller family size. However, during the same time period the national average number of monthly food stamp recipients fell by only 6 percent. Adjusting for household changes in the District that account for 7 percent of the caseload drop, the city's food stamp rolls still declined at double the national rate. Serious problems with program administration and outreach likely are to blame.

An outreach coordinator position, critical to ensure that families learn about the opportunity for assistance, was eliminated because of budget constraints. Once families learn about the program, though, it also is essential that the program be operated in a way that lets families get the benefits to which they are entitled. Unfortunately, this is not happening.

In 1989 D.C. Hunger Action volunteers, posing as prospective food stamp applicants who had emergency food needs, called District food stamp offices and found that:

- Thirty-nine percent of their calls went unanswered.
- Ninety percent of the workers who did answer did not identify

the callers as being entitled, under federal law, to expedited emergency processing of an application.

- Twenty-eight percent of the workers who answered refused to mail an application for food stamps, although federal regulations require them to do so.
- Sixty percent of workers did not provide information on the necessary documentation to bring to the application interview -- essential information to speed approval of the application and to begin providing help.

Legal counsel for a class of District food stamp applicants facing similar barriers reached a settlement with city officials in June 1991 to improve application procedures. District application processes will require careful monitoring to ensure that these improvements take effect.

Because the federal government pays *the entire cost* of food stamp benefits (although states and the District share in the costs of food stamp administration), it is inexcusable that poor families in the District miss out on this benefit.

### Child Support Enforcement

By federal law, each state that operates an AFDC program also must provide child support enforcement services to both AFDC families and to non-AFDC families that request child support enforcement assistance. The child support enforcement office must help with locating absent parents, establishing paternity and support orders, and collecting child support when payments are due. Federal matching funds are available on a very favorable basis for this program: in addition to a federal match of 66 percent for all administrative expenses connected with child support enforcement, each state (and the District) is entitled to incentive payments and to a portion of collections made on behalf of AFDC families. These payments help offset the cost of providing AFDC benefits to the family.

The state-federal child support program in the District is administered through the Office of Paternity and Child Support Enforcement (OPCSE) within the Department of Human Services. OPCSE historically has been underfunded, understaffed, and unable to cope with the large demand for services.

The legacy of many years of bureaucratic neglect is a program that fares poorly compared with other state agencies. In FY 1988, the last year for which national data are available, the District ranked fiftieth among states in the percentage of its average annual child support enforcement caseload for which a collection was made on an obligation. It ranked fiftieth in the percentage of AFDC assistance payments that were recovered through child support collections, and it ranked thirty-fourth in the percentage of collections received. In total child support collections per dollar of administrative expenditures – a basic measure of administrative efficiency – the District ranked last.

As of 1987 paternities were established for only 168 out of every 1,000 children born out of wedlock in the District – far below the national rate of 273 paternities per 1,000 children, and dismally below the rates in leading states (681 per 1,000 in Delaware, 636 per 1,000 in Michigan, 523 per 1,000 in New Jersey, 748 per 1,000 in Vermont, and 595 per 1,000 in Wisconsin).

With better administration in recent years, child support enforcement in the District has improved significantly. Total collections went from $3.9 million in FY 1984 to $14.1 million in FY 1989. In FY 1989 the District collected $1.56 in child support for every dollar spent on child support enforcement – up from a rate of 90 cents per dollar in FY 1984. The total number of paternities established went from 471 in FY 1984 to 2,079 in FY 1989.

Despite these rapid improvements, however, the agency remains without the funds necessary to meet even its most basic obligations under federal law. The FY 1991 budget is $2.37 million, virtually the same amount as in the past three years. Since this does not cover salary increases, level funding really means a reduction in funding for services.

The budget request will allow the agency to establish paternity and obtain child support awards in 6,385 cases, about the number of new cases that will enter the child support enforcement system in FY 1991. The budget does not allow for any progress in processing the backlog of tens of thousands of cases. According to the agency's collection analysis for FY 1989, the agency had 69,817 cases, of which only 15,967 cases had a support order.

Insufficient funding to serve these cases has serious consequences:

- Many families will go without child support, including families in which the absent parent has a significant income.
- The District will be unable to meet federal requirements, effective October 1990, that set specific time frames for how quickly states must process child support enforcement cases. For example, the District now is required to file a petition for paternity or serve legal papers on the alleged father in a paternity case within

90 days of locating him. It must either establish paternity or exclude from paternity the alleged father within one year of serving him with court papers. New federal requirements also require each state to meet paternity establishment performance standards, which the District will have great difficulty meeting unless it takes aggressive measures to reduce its backlog of cases that need paternity established.

- The District will continue to be subject to federal financial penalties for failure to meet federal child support enforcement requirements. It already has been assessed a penalty of more than $500,000 for failing a FY 1985 audit, is currently being re-reviewed for failing the FY 1986 audit, and still is being audited for FY 1989.

- Funding uncertainties may jeopardize timely installation of an automated data processing and case management system required by federal law. States are required to develop automated tracking and monitoring systems, which are essential if states are to keep track of child support payments, promptly flag cases when

### Improved Paternity Enforcement Efforts

When a child is born out of wedlock, the child's paternity must be established before the alleged father can be ordered to provide child support. Effective paternity establishment is especially important in the District, because many children are born out of wedlock. In 1987 three in five births in the District were to unmarried women.

The District Office of Paternity and Child Support Enforcement (OPCSE) is taking new steps to encourage voluntary acknowledgment of paternity (rather than a prolonged, contested procedure that often polarizes the parents) and to speed processing of both voluntary and contested cases. These procedures offer hope for a faster, more effective process. For example, the OPCSE allows parents willing to acknowledge paternity voluntarily to do so in court on the same day the paternity case is heard or soon thereafter. In the past it could take 18 months to establish paternity. The OPCSE administrator estimates that 60 to 70 percent of paternity establishments now are accomplished through this process.

> payments fall behind, and take quick corrective action to keep child support payments coming to a family. Most of the cost of installing such a system – 88 percent – is borne by the federal government, but the opportunity for this enhanced federal match expires in 1995.

At least some partial help with funding is in sight due to new District legislation, but it will not replace the need to continue to increase the program's annual budget to accommodate needed staffing and program enhancements. The new legislation provides that federal incentive payments to the city based on its program performance must be automatically appropriated to the child support agency and used for child support enforcement purposes. Previously, incentive payments earned by the District simply went into the D.C. General Fund, rather than being available for program improvements. This legislation immediately makes available to the OPCSE incentive payments for FY 1989 and FY 1990 that total $1.4 million. This additional funding will allow the District to hire new staff. However, this supplemental funding is a one-time payment, and future incentive payments will fluctuate from year to year. At the same time staffing and program needs will grow.

The OPCSE also has established same-day blood testing in paternity cases in which the alleged father contests paternity. A laboratory is located next to the courtroom in which paternity cases are heard, and an alleged father is ordered to report for blood testing if he appears in court and denies that he is the father. These blood tests now are highly accurate and can be used both to establish and to preclude paternity. The laboratory has a computerized hook-up with OPCSE, so that results are available to the agency as soon as they are available at the laboratory. OPCSE then can respond immediately by moving to dismiss the case if the tests are negative or to establish paternity if the tests are positive.

OPCSE also is establishing a project, in cooperation with the city's Division of Vital Statistics, designed to counsel fathers of newborns at the hospital about their rights and responsibilities and to secure their voluntary acknowledgment of paternity at that time.

In addition, new legislation enacted by the City Council establishes a special police unit responsible for serving legal papers on putative fathers and makes it more difficult for defendants to evade service.

## Recommendations

Poor families in the District, like poor families nationwide, often try, against all odds, to support their children through hard work. We must provide them with every support we can in their efforts: no parent should work full time and still see his or her children grow up in poverty. At the same time, since many of the District's families with children cannot make it on their earnings alone, the District must ensure that there is a strong safety net of child support, AFDC, and food stamps to help meet the basic needs of poor families. Assistance must be provided to help families threatened with imminent emergencies such as homelessness. The District also must help parents gain the skills they need to support their families. Programs should be structured to reward and support parents struggling to become self-sufficient, rather than to penalize them for their efforts.

### *Provide greater job and training opportunities.*

- To ensure that the District's poor families and children can benefit from the city's comparative affluence, the District government must join with major local employers, including the federal government, to improve access of local workers to stable employment. Such a partnership must work to improve the employment prospects of young workers by providing quality education city-wide, skills training, apprenticeship programs, adult education programs, English as a Second Language classes, and affordable child care, and by assuring that employment practices guarantee equal opportunity and equal treatment.

- Because many of the District's children are poor even though a parent works, we must boost parents' earnings through public and private action. Employers should make sure that wage levels are adequate to support a family, that eligible workers get advance payments of the federal Earned Income Credit to supplement their wages, and that employees and their dependents have employer-provided health insurance.

### *Increase assistance for working families.*

- The District can encourage families receiving AFDC to work by allowing families to keep more of their earned income without having their grants reduced. Given the importance of encouraging youths to take full advantage of education, training, and employment programs, the District also should take full advantage of AFDC options to provide incentives to youths who are trying to build their skills by allowing them to keep earnings or stipends while enrolled in such programs. The District also should consider using Family Support Act and other funding to create a comprehensive system of supports, including appropriate child care, for AFDC teen parents struggling to finish high school or obtain a GED.

*Enhance child support enforcement.*

- A recently completed Office of Paternity and Child Support Enforcement (OPCSE) resource allocation plan estimated that OPCSE, the Office of Corporation Counsel, and the Superior Court need an additional 108 full-time positions to manage the child support caseload adequately. In addition, the plan recommends a temporary project to clear up 20,000 cases now awaiting paternity establishment services. The city should move swiftly to fulfill these objectives.

*Help AFDC families afford housing.*

- District families on AFDC face staggering barriers to finding affordable housing. The District should provide an AFDC special needs rent supplement to recipients whose housing costs are greater than 30 percent of the grant. A one-time revision of the standard of need and the grant level to adjust for increased housing costs, coupled with retention of annual cost of living adjustments, also would help families get sufficient income to remain housed. The District also should provide other housing-related assistance (such as necessary security deposits) through special needs grants to bring in additional federal matching funds.

- The District should institute presumptive eligibility for families that are clearly eligible for AFDC and need the assistance to remain housed, or to leave the shelter system. For some families, prompt AFDC assistance may help avert or resolve a housing crisis. While 17 states process an AFDC application within 30 days, the District of Columbia takes 45 days – a lengthy process for families in need. Fourteen states provide AFDC assistance prior to a complete determination of eligibility when the facts support a presumption of eligibility.

- The Emergency Assistance program should be expanded to obtain federal matching funds for housing-related services for needy families. The District uses the Emergency Assistance program to provide some housing-related services to poor families (including poor families that do not receive AFDC). However, the District does not use this program to provide services that other localities or states have found effective in helping families find housing once they have become homeless – for example, housing search workers who work with homeless families and potential landlords, and child care for homeless children so a parent can search for housing and employment.

*Address shortfalls in staffing.*

- The city should hire more caseworkers and supervisors to determine family eligibility for assistance and to respond better to families' needs when they are in crisis. Hiring freezes that result in a system too overloaded to respond quickly are not in the best interests of families.

*Restore cuts in public assistance.*

- The City Council and Congress should restore the reductions in public assistance made as part of the FY 1992 budget. Children and families will be hurt further if the FY 1992 proposals to reduce benefits in the AFDC program by 4.5 percent and to suspend the annual cost of living increase in AFDC are allowed to stand. It is also unacceptable to reduce General Public Assistance benefits for adults with physical and mental disabilities in order to meet the costs of providing AFDC to increasing numbers of needy families with children.

- Steps should be taken to ensure that federal penalties assessed against the District's AFDC funds because of past child support enforcement inadequacies do not harm AFDC children.

*Strengthen food stamp outreach.*

- Reinstate the position of outreach coordinator and target funds for outreach to potentially eligible families. Such outreach may be done effectively through contracts with community-based groups that work with low-income families.

- Exempt food stamps from the current freeze to allow the hiring of enough workers to serve food stamp applicants promptly and properly and to identify cases entitled to expedited emergency processing.

- Provide ongoing training to workers to ensure that they understand food stamp procedures and are capable of properly counseling families about their rights and responsibilities.

# Management and Budget Practices:

## How They Affect the District's Children

Against almost every conceivable measure, the status of children in the nation's capital is deeply disturbing. Many of the severe shortages in services for children and families are not simply the result of inadequate spending levels, but are caused by ineffective management and a budget process that impede the implementation of critically needed children's programs. Even when the city spends a lot in a given area, often there is an enormous gap between what is spent and the actual benefit for children. The story of programs for children and families in the District is a story of missed opportunities. The District frequently fails to fund or implement programs of proven cost-effectiveness, ignores opportunities to capture federal funds for which it is eligible, and fails to spend funds it has received. For example, the District:

- Underspent its FY 1989 drug treatment budget by $2 million, although it has very few drug treatment programs for youths, pregnant women, and mothers and their children.

- Lost available federal revenue for 35 percent of the children in foster care at a time when its own foster care funding was far below what was needed.

- Did not take full advantage of the federally assisted Medicaid program for pregnant women and children, resulting in many eligible women and children receiving no health services and the city paying 100 percent of the cost of care for those who were served.

- Failed to spend $47 million in federal funds over the past 15 years that could have been used to renovate vacant public housing units desperately needed by families.

- Failed to spend $1.2 million in federal dollars it received for AIDS prevention in FY 1989.

## A Budget Process That Hurts Children

The absence of sound planning and coherent development of the city's yearly budget undermines the effective delivery of services for children. The amount the city budgets each year for children's programs often bears little resemblance to what is spent. The Mayor's Budget Office annually develops spending and revenue assumptions for each agency, often without consulting agency managers. As a result, in past years some programs spent far more than their appropriated budget when the need exceeded what originally was anticipated. At the same time, other programs could not spend all their funds because of across-the-board freezes or administrative delays in contracting for services, purchasing equipment, or hiring staff.

For example, the budget for children's mental health increased over the past four years but the agency has been spending millions of dollars less than approved levels because of hiring freezes and restrictions on use of funds to purchase services and supplies. As a result, its unspent funds have been diverted to cover deficits in adult mental health services, while children's needs continue to go unmet.

In contrast, the foster care program, which until 1989 showed little actual increase in its budget over the prior eight-year period, was spending several million dollars more than what was budgeted each year largely because of increasing caseloads. To fund the foster care program, money had to be diverted from unspent funds in other agencies, such as the Commission of Public Health, which also provide essential services to children.

### Personnel and Operating Deficits

The spending and revenue estimates, determined by the Mayor's Budget Office, often are unrealistic, leaving many children's programs with insufficient funds to complete the fiscal year and creating deficits in these programs. For example:

- Spending and revenue estimates frequently are developed without consulting the managers who run the programs. As a result, spending assumptions often fail to anticipate and plan accurately for the growing number of children and families needing services.

- For the past few years, revenue estimates have overstated, by as much as $2 million, federal revenues to help pay the costs of foster care and emergency assistance to homeless families --

mainly because the city failed to capture reimbursements available from the federal government in these areas. Revenue overestimation usually results from planned improvements in revenue collection that never take place. Sometimes federal claims are rejected.

- Child-serving agencies often lack funds to pay for energy, utilities, and rent simply because spending assumptions fail to take into account inflationary increases or newly negotiated and more costly contracts in these areas.

These inaccurate spending and revenue estimates then are used in the next step of the District budget process. The Mayor's Budget Office establishes for each agency a spending ceiling, known as a "mark." Because revenue often is overestimated and actual spending is underestimated, many children's programs receive "marks" that are far too low. According to former city officials, most of the programs housed in the Commission on Social Services, for example, have received marks for the past four years that are not sufficient to pay even for the current on-board staff needed to maintain existing levels of service, creating deficits in these programs.

The Mayor's Budget Office and the District Council have allowed the deficits in spending for personnel to continue. They exacerbated the problem by supporting pay raises for several years which, because they were unfunded, increased the cost of on-board staff and made the personnel deficit even higher.

Moreover, to achieve cost savings, the Council and the Budget Office repeatedly have reduced financial support for supposedly funded staff positions that were vacant. In fact, most of these vacancies never were really funded to begin with. This practice of eliminating funds for unfunded vacant positions saves no money yet gives the illusion of cost-effective streamlining, while at the same time overburdening agencies that are already grossly understaffed.

Deficits also have been building for years in nonpersonnel areas, including the cost of energy, utilities, and rent under local service contracts. Most of these costs are negotiated not by the programs that pay for them, but by the centralized Department of Administrative Services (DAS). DAS often fails to convey accurate and timely information about cost increases in these areas to those developing program budgets. As a result, the agencies own projections are off, producing deficits.

## The District's Annual Budget Process: A Complex Local-Federal Maze

| | |
|---|---|
| **August - February** | **Mayor** and **Financial Management Team** set agency budget ceilings.<br>**Departments** and **Agencies** draft budget requests.<br>**Financial Management Team** makes revenue and spending recommendations.<br>**Mayor** submits budget to the **Council**. |
| **March** | **Council** holds hearings and approves a budget.<br>**Mayor** signs or vetoes the **Council**-passed budget (**Council** can override a veto by a two-thirds majority). |
| **April** | **Mayor** forwards city's budget to **President** for review.<br>**President** and **Office of Management and Budget** must review budget and submit to Congress by April 15. |
| **April - June** | **House** and **Senate** hold separate hearings and accept, reject, or modify the city's budget. |
| **July - September** | **House** and **Senate** differences in the budget are resolved by joint **House-Senate conference committee.**<br>**House** and **Senate** each must finally approve the budget.<br>**President** receives the city's budget for final approval or veto. (If vetoed, **Congress** can override a veto or change the budget and return it to the **President** for his signature.) |

## Indiscriminate Cost Containment Policies

For the past four years, the city has attempted to reduce its budget deficit by placing across-the-board freezes on hiring personnel and on purchasing equipment. These efforts at cost containment have failed to distinguish between inefficient and efficient programs, between programs that generate revenue and those that do not, and between direct service agencies with severe staff shortages and administrative offices that are bloated. These freezes, because they have not been implemented discriminately, not only have an adverse effect on children and families, but often fail to achieve the desired cost savings.

Past freezes have been applied to such programs as child support enforcement, which generates revenue; prenatal care, which saves more than $3 for every dollar spent; and AIDS prevention, independent living activities for youths in foster care, and substance abuse treatment initiatives, which have been 100 percent federally funded.

Across-the-board freezes also are crippling many programs that, either by their nature, by law, or by specific mayoral directive, cannot close intake or cut back. District law, for example, does not allow Child Protective Services (CPS) to place an explicit limit on the number of abuse or neglect reports it will investigate. In reality, because of severe staff shortages and increased caseloads, CPS is forced to make decisions every day about which reports to investigate and which to ignore, potentially leaving some children in danger.

Other examples are Aid to Families with Dependent Children (AFDC) and Medicaid, which are both entitlement programs: all who are deemed eligible for these programs are allowed to receive benefits, irrespective of the total number of recipients or the the cost of providing these benefits. By law, the city cannot refuse benefits to persons who meet eligibility criteria, nor can the District deny persons the right to apply and have their applications acted upon in a timely fashion. In reality, eligibility determination workers -- with more than 150 vacancies -- cannot keep pace with demand. To ensure that such mandatory programs are funded, funds often are reprogrammed from other discretionary (non-entitlement) children's programs, such as child mental health and day care, thereby causing shortfalls in these programs as well.

Hiring freezes also affect programs that must, because of court orders or consent decrees, maintain certain minimum staffing levels. The Youth Service Administration's juvenile detention programs are understaffed and therefore the District must spend millions on overtime pay to meet court-ordered staffing requirements -- indeed, millions more than it would have had to spend had it hired the necessary permanent staff.

## Failure To Implement Children's Programs

Even when the city has appropriated funds for children's programs, administrative barriers often frustrate attempts to spend appropriated funds.

### Inefficient Centralization of Support Functions

The District needlessly centralizes the final responsibility for virtually every support function needed to implement programs – personnel, contracts, procurement of equipment and supplies, facilities maintenance, legal help, and financial management and control. This overcentralization delays start-up of new programs and hinders necessary improvements in existing programs. Many of the "tools" needed to implement programs are outside the control of program managers and in the hands of people in other departments who often are unfamiliar with the needs of the clients. Hiring processes are controlled by a centralized Department of Personnel. Contracts for many items, such as leases, guard services, computer equipment and systems, and supplies costing more than $10,000 are controlled by a centralized Department of Administrative Services. Spending is controlled by the centralized financial management system. Within departments such as the Department of Human Services, legal services, facilities management, and procurement of even small amounts of goods and supplies are centralized at the top. While some central oversight obviously is essential, the District's system consistently chills innovative practices and creative administration.

To illustrate how cumbersome and deadening this structure is, consider the many steps a program manager must climb to improve a program. To purchase a computer to expedite child support enforcement, the child support program must go through five separate offices (Commissioner's Office, DHS' Central Controller's Office, DHS' Central Management Information Office, DHS' Central Procurement Office, and the Department of Administrative Services), each with its own multiple steps. In addition, major purchases may require the approval of the D.C. Corporation Counsel, as well as federal agencies. The Commission on Budget and Financial Priorities (the Rivlin Commission) documented in its November 1990 report, *Financing the Nation's Capital*, the many steps needed simply to hire personnel.

Like the game of "telephone" that children play, agencies' initial purchase requests often get garbled many times over in this cumbersome process. The structure also makes it impossible to hold anyone accountable. Thus, when a small nonprofit agency providing services to the

District government does not get paid for months because of an unwieldy system (aggravated by spending freezes and slow-downs), it is not clear who is responsible or who can fix the problem.

### Lack of Interagency Coordination

Services for children suffer when budget development and program implementation are not coordinated among the many agencies that serve them. Budgets for health, foster care, mental health, and juvenile justice are developed and implemented separately, even though the programs serve many of the same children and families and often provide or pay for similar services -- some federally matched and others not. The failure to coordinate services leads to fragmentation, needless duplication, and inefficient use of available federal funding, when it's available, to underwrite comprehensive cross-agency services.

The Medicaid program and its relationship to other critical child health and child welfare activities provide a key example of this failure to coordinate across agencies. Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, historically the largest source of publicly funded comprehensive primary care for poor children, was modified in 1989 to require states to furnish children with all medically necessary care for physical or mental disabilities and conditions identified through screening. The definition of "medical assistance" under Medicaid is extremely broad and thus permits a major reconfiguration of how comprehensive services for Medicaid-eligible children with physical, mental, or developmental disabilities can be financed. The cost of many of the therapeutic and health-related services needed by children with disabilities in the city's special education, child welfare, and mental health systems (including the 280 children in out-of-state residential treatment at an average cost of $80,000 per child to the city) now can be borne in great part, if not exclusively, by the federally matched Medicaid program.

Despite these significant EPSDT changes, the city has not examined the potential effect on numerous child-serving agencies and programs. With careful redesign and modification and an aggressive effort to assure that children receive the EPSDT screenings and treatment to which they are entitled, the District could recapture 50 percent of all Medicaid-covered expenditures made on these children's behalf. However, the District continues to have one of the lowest EPSDT participation rates in the nation, missing an enormous opportunity to recover expenses and help more children.

### Failure To Maximize Federal Revenues

The District has been plagued by an inability to maximize federal revenue from either federal entitlement or grant programs. In the children's area, this has been particularly evident in the areas of foster care, child support, and emergency assistance to the homeless. For example:

- Eight years ago, the District claimed federal financial assistance for about 60 percent of the children in foster care. In 1988 it was claiming federal reimbursement for only 22.6 percent of the children in care. This represents a substantial revenue loss of millions of dollars for the city.
- The District spent only $12,000 of the $635,000 in federal funds available to it in FY 1987 under the federal Independent Living Program, even though the funds were available with no local match required. The program is designed to help older youths in foster care make a successful transition to independent living when they leave care. The Inspector General in the federal Department of Health and Human Services found that the District forfeited $623,000.
- During the period of most rapid growth in the number of homeless families (1985-1989), the District failed to submit all of its federal claims for emergency assistance payments to the homeless, losing more than $4 million in revenues over this period.

The District fails to capture its full share of federal funds for various reasons, including: (1) severe staffing shortages in key program areas, (2) lack of standard operating and recordkeeping procedures, (3) lack of training of staff to understand reimbursement policies and procedures, and (4) inadequate and poorly supported management information systems.

The child welfare program offers a telling illustration. It could be generating millions more in federal revenues under the federal foster care program, which is authorized under Title IV-E of the Social Security Act. Eight years ago, the city's foster care and adoption assistance programs instituted a new automated management information system called the Ward Tracking System (WTS). It was supposed to hold complete data on children in foster care, including services provided, payments made, and demographic data. In short, WTS was to provide all the information needed to support reimbursement claims to the federal government. WTS, in time, was to cover children (and, indeed, many of the same children) in other systems as well, such as juvenile justice and mental health, recognizing that they, too, might be eligible for federal dollars. Since implementation of WTS, claims have declined by 50 percent because the city government:

- Programmed WTS in a computer language unknown to anyone in the child welfare system – in fact, unknown to most of the programmers government-wide.
- Failed to hire sufficient or trained staff to operate WTS and failed to train the front-line workers upon whom WTS relies for data.
- Failed to keep WTS current on changes in federal reimbursement policies (largely because it had no one on staff who knew how to reprogram changes).
- Failed to put in place standard procedures for recording data and submitting claims.
- Used a system for processing claims that involved multiple layers of government, each operating under its own guidelines.

The tragedy of the WTS story is that, properly maintained, supported, and staffed, it could provide the District with an invaluable information base, not only for maximizing revenue, but for policy and program analysis, for treatment planning, for keeping better track of children in care, and for coordinating services and spending across agencies.

### Financial Management System

The District's internal procedures for submitting federal claims and for applying for discretionary grant dollars are cumbersome. They involve multiple layers of bureaucracy and the inevitable lack of communication among program administrators. This is a particular problem in the large, heavily centralized Department of Human Services.

Spending is controlled in the District through its centralized accounting system – the Financial Management System (FMS). All agency budgets are entered into the system. These are made up of "appropriated" local funds or "non-appropriated" federal funds. When appropriated funds in a program budget are in deficit, as they often are because of structural personnel deficits and inaccurate spending and revenue estimates, the system may restrict a program's spending of its "non-appropriated" funds as well.

*(continued on page 142)*

## The Federal Government and the District's Children

The federal government affects the welfare of children in the nation's capital enormously. The District's status as a federal jurisdiction means that Congress and the President of the United States have final authority over the District's spending and legislative decisions. In addition, as the Rivlin Commission and others have documented, the extraordinary federal presence in the city places great fiscal constraints on the city, inhibiting its ability to care adequately for its children.

### Lengthy and Complex Budget Process

The District is the only jurisdiction in the country whose annual budget is subject to both local and federal review. Each agency's budget must be reviewed and approved, not only by the District of Columbia mayor and the District Council, but by the federal Office of Management and Budget, the U.S. Congress, and finally the President of the United States. The process takes nearly a year to complete and inevitable emergencies and budget shortfalls require mid-year adjustments. Adjustments over the past years in children's program most often have been in the form of requests for supplemental funds to compensate for incorrect initial revenue and spending assumptions. Even the smallest mid-year corrections must follow the same lengthy budget review process.

### No Autonomy Over Spending and Legislation

The District has no final control over its expenditures. It is not uncommon for members of the U.S. House of Representatives and the Senate to place restrictions on how the District and its residents spend local as well as federal funds by amending the District's budget to reflect their own priorities and beliefs. This not only undermines the decisions and choices that District leaders and taxpayers have made, but often slows down the city's budget process.

### Fiscal Constraints

The presence of the federal government in the city restricts the District's ability to raise revenue in a number of ways. For example:

- Federal law prohibits the District from taxing income earned in the city by non-residents, which, according to the Rivlin Commission, represents about 60 percent of the total income earned in the District. The Rivlin Commission found that this prohibition costs the city from $870 million to $1.2 billion each year.

- Federal buildings and properties are tax-exempt and together with other tax-exempt properties remove about 55 percent of all real property from the tax rolls.

- The federal payment, which in theory is designed to compensate the city for the costs of the federal presence, has declined over the years in both real terms and as a percent of the District's budget. This gap between the District's costs and the actual payment has left an extraordinary financial burden on the city and its taxpayers.

  - In real dollar terms the federal payment has decreased 13 percent since the advent of home rule in 1975. Between FY 1988 and FY 1991, the basic federal payment was frozen at $430.5 million.

  - In FY 1975, when the federal and local government was smaller than it is today, the federal payment made up 24 percent of the city's annual operating budget. By FY 1991 the federal payment had declined to 14 percent of the operating budget and was $300 million less than it would have been had the federal government maintained its proportional commitment to the District.

As a result of Mayor Dixon's leadership, activity is now under way to address both the level and predictability of the federal payment – and there is cause for optimism. In February 1991 Congress appropriated an additional $100 million for the payment for FY 1991. A federal payment of $630.5 million for FY 1992 also has been approved by Congress and temporarily is held up by the presidential veto of the overall District budget. Legislation also has been approved that would make the federal payment a formula-based entitlement that would not be subject to yearly fluctuations or across-the-board cuts by Congress. Such changes will enable the city to better develop long-range plans and make financial investments. Under the formula, the federal contribution would increase about $100 million over the next three years.

In other cases, federal or foundation grants are not spent because a program's grants are not loaded into the system. Months may go by from the time a program receives notice from the federal government or a foundation that it has been awarded a grant to the time FMS "loads" it.

Even when the District successfully captures federal grant dollars, it cannot always spend them to benefit children. Programs may be unable to spend federal grant dollars because of indiscriminate spending freezes or lengthy hiring and contracting procedures. Periodic FMS shut-downs and slow-downs also hold up funds and no distinction is made between local and federal funds. In addition, programs, such as maternal and child health, child mental health, foster care, and child support, that generate federal reimbursement revenue often cannot "keep" the revenue obtained to expand their own services. Payments made on federal claims instead go into the general account. As a result of these practices, children's programs that once would have sought out federal and private grants aggressively are discouraged from doing so.

## Lack of Investment in Cost-Effective Preventive Programs

The result of these financial management and administrative failures is that many cost-effective preventive programs are shortchanged. Much of what the District actually spends on children is for high-cost, restrictive, and often inappropriate programs, such as juvenile detention centers, residential treatment facilities, long-term foster care, and "welfare hotels." The District has among the highest rates of neonatal intensive care use, juvenile incarceration, out-of-state residential placement, and long-term foster care in the country.

In contrast, the city spends too little on prevention, early intervention, and diversion programs, which repeatedly have been shown to be more beneficial for most children and more cost-effective.

- About $25 million a year is spent by the Commission on Mental Health on residential treatment facilities for children. Very little is spent on less restrictive and less costly community-based therapeutic foster care, group homes, and respite services.
- Approximately $14 million a year is spent by the child welfare system to support children in foster family homes or group homes. Yet very little is spent on in-home crisis and family support services to prevent removal of children from their families.

- Millions of dollars are spent to provide intensive care to the hundreds of infants born too sick or too small, but services at public maternity clinics are defunded and reduced.

- Almost $21 million is spent by the juvenile justice system on detention centers, but only about half that amount is spent on community-based alternatives to detention.

- Millions of dollars are spent on hotel rooms for homeless families, while very little has been spent on programs to help support families and prevent homelessness.

The tragic irony of the District's failure to spend more on cost-effective prevention, early intervention, and diversion programs is that all too often the monies *are* available, but, because of detrimental administrative and financial management practices, the funds are not spent wisely.

## Recommendations

It is clear that significant gains for children and families in the District will not be made unless steps are taken immediately to reform a number of management and budget practices. Improvements are needed in the budget development and implementation process, procedures for program management, and in efforts to maximize the federal revenues the District receives. The reforms must cut across systems and change the way agencies and offices responsible for child and family well-being go about doing their jobs.

The mayor, key members of her administration, and the City Council together must undertake targeted program reviews to determine the real gaps in funding and the steps necessary to meet children's needs; the excess funds that exist and how funds can be used more appropriately; where federal revenues can be increased; and where funds can be redirected from expensive maintenance programs to more cost-effective prevention, early intervention, and diversionary programs. For children to benefit, specific steps must be taken to institute necessary systemic reforms. At a minimum, the following changes must be made:

### *Improve budget development and implementation.*

- Develop spending assumptions in close consultation with program managers so that they accurately reflect anticipated growth in the number of children and families needing services.

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Similarly, program managers need timely and accurate information about administrative and overhead cost increases.

- Reject indiscriminate across-the-board freezes in contracting for services, purchasing equipment, or hiring staff as a budget control device. Decisions about cost containment measures should exempt direct service programs that already suffer from severe staff shortages and cannot limit their services, programs that generate revenues for the city, and programs that are of proven cost-effectiveness.

- Address deficits in personnel spending by changing the existing D.C. Personnel Act and the federal personnel regulations to allow for targeted reductions in force or in grade where there is excess, and redistribution (and necessary retraining) of staff where there are shortages. In areas that have unacceptably high client-to-staff ratios, as in child welfare, new hires must be allowed.

*Improve program management.*

- Coordinate program initiatives across child-serving agencies, maximize resources, and develop comprehensive services for children and families with multiple needs. Investments in community-based therapeutic settings, in-home services, substance abuse treatment, and case management can be made using Medicaid, foster care, education, and juvenile justice dollars.

- Child-serving agencies should work together to develop budget initiatives and management information systems that will enhance efforts at interagency coordination.

- Program managers should have greater control over their budgets and spending. The city should institute a system of rewards that supports good managers.

*Maximize federal resources.*

- A cross-system effort should enhance federal revenues under Medicaid, the Title IV-E Foster Care and Adoption Assistance programs, the Supplemental Security Income Program, the Child Support Enforcement Program, and other federal programs. To facilitate appropriate claiming of federal funds, procedures must be implemented to ensure accurate eligibility determinations, full training of staff in relevant procedures, the institution of tracking systems, and programmatic improvements.

- Ensure that programs that generate expanded federal revenues reinvest funds that are received in expanded preventive and community-based services rather than having the money revert to the general fund.

- Revise the city's central Financial Management System so that federal and foundation grant monies can be accessed and spent more efficiently. Grants currently in the system should be exempt from any imposed spending freezes.

# What You Can Do for the District's Children:

## Suggestions for Community Action

Washington, D.C., is a city of incredible resources, yet children rank at the bottom of almost every indicator of health and social well-being. We must begin to channel public and private resources to make our children first instead of last. The changes needed to improve the lives of our city's children and families will not be achieved unless each and every one of us begins to insist that children are our highest community priority. Our children need the support that only an involved and caring community can provide.

How can you help? A first step is to educate yourself about the circumstances of children in the city. A second step is learning about the many wonderful programs now operating to help children. CDF's Child Watch Visitation Program is one way to see first-hand both children's needs and the programs that work to serve them.

Through Child Watch, CDF has learned about the many excellent programs and committed individuals and organizations in this city working to provide quality services for children and families.

### Programs Helping District Children

Good programs share common characteristics that contribute to their success. Whether they are sponsored through public or private agencies, formally or informally organized, or serve residents in a single ward or throughout the city, they exist because of support from a broad spectrum of the community – concerned individuals, businesses, foundations, religious congregations, and civic organizations.

Just by looking at several of them one clearly sees their strengths. These programs:

- Tailor their services flexibly to the individual needs of the children served.
- Seek to help children by supporting their families.
- Help connect families with resources in the broader community.
- Develop roots in the community and build on a community's strengths.
- Nurture mutual respect and trust between the staff and the children and families served.
- Foster a strong commitment by all staff to the program's goals.

The following programs provide examples of how these strategies are being used to help District children. (Program addresses, telephone numbers, and contact names are listed in Appendix C.)

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**The Family Place** opened in 1981 in the basement of the Church of the Savior to help mothers in the neighborhood get regular prenatal care and to help them care for their infants and toddlers. Every weekday between 9 a.m. and 5 p.m. dozens of pregnant women and new mothers -- most of them recent immigrants from Central America -- come to the row house in Adams Morgan the Family Place now owns to find the kind of help they could have gotten from their extended families back home. It's a place a mother can come to when she's frightened about her baby's illness, when she needs relief from coping with a willful toddler, when she's threatened with eviction, or when she's just looking for someone with whom to share a cup of coffee.

Although the atmosphere is easy and informal, the Family Place is clear about its primary mission: to make sure women get early and regular prenatal care and parenting education, and that their young children get pediatric care. Clients also are assisted in finding housing, child care, jobs, and legal assistance. English as a second language and basic skills classes are conducted on-site.

The Family Place is funded primarily by foundations, the Church of the Saviour, other community churches, and by individual donors.

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**The Community Partnership for the Prevention of Homelessness** was established in the Fall of 1989 to coordinate public and private resources concerned with addressing the needs of individuals and families in the District who are at risk of becoming homeless, as well as those who are returning to the community from emergency shelters. The Community Partnership's Board of Directors includes representatives from the District government, nonprofit homeless service providers, community members, and the business sector. One of its main activities is implementing a neighborhood-based strategy for preventing homelessness. The **Anacostia/Congress Heights Partnership for the Prevention of Homelessness** is the first of these neighborhood efforts.

The Anacostia/Congress Heights Partnership helps coordinate and develop resources that address the housing, education, employment, health care, and recreation needs of children and families. The partnership has worked with residents in the Sheridan Terrace housing project, collaborating with ConServe and the Washington Legal Clinic for the Homeless. ConServe helps stabilize families at risk of becoming homeless by providing rent subsidies and by linking families with social services, including child care, employment, family counseling, and mental health services. The Washington Legal Clinic for the Homeless provides legal representation for families that are at risk of being evicted from their units or living in unsafe or substandard units. The Partnership also organizes and develops leadership, empowering residents to obtain adequate services for their families and communities.

The work of the Partnership is funded primarily by foundations and corporations.

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**The Edward C. Mazique Parent and Child Center** is a comprehensive early childhood education and child care program that operates on the belief that to serve children properly, the parent must be recognized as the primary educator. The center started in 1969 as one of 36 Parent-Child Centers across the country. The goal of these programs was to provide coordinated and comprehensive social services for parents and their young children and to provide parents with the knowledge and resources needed to promote their child's growth and development.

The Parent and Child Center's programs include center-based child care in three sites for more than 250 children ages six weeks to five years. This includes meals, on-site medical services, and educational and therapeutic services for children with special needs. The center also provides a home-based comprehensive child development program for families with children younger than five and pregnant women, a Junior Parent Program that teaches parenting skills and enables teenage parents to return to school or become employed, and a Parent-Child Resource Center that operates out of two community health care centers to provide comprehensive case management to pregnant women and families with children younger than one.

The Mazique Parent and Child Center is funded by federal and District government grants, foundations, United Way contributions, and gifts from individuals.

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**The High Intensity Supervision (HITS) Program**, operated and funded by the D.C. Superior Court's Division of Social Services, provides an effective alternative to incarceration for youths ages 14 to 18 who are adjudicated delinquent. Most of the youths referred to the program are repeat offenders. In 1990 the HITS program worked with 200 youths and their families, providing intensive individual and family counseling, drug counseling, and group discussions on issues such as drugs, self-esteem, and parenting. Youths in the program are expected to be enrolled in school or job training programs or to be employed. HITS contracts with other organizations to provide job readiness training, school-to-work transition programs, and educational support services. In addition, caseworkers work with families, organizing parent support groups and providing parent education.

With staff carrying caseloads half as large as most probation officers, the program is able to provide intensive services to youths and their families. As a result, while the recidivism rate for juvenile parolees in the District is about 30 percent, the rearrest rate for HITS clients is only 5 percent. The program also is cost-effective, running about $20 per day, per youth -- one-sixth the cost of a residential facility such as Oak Hill.

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The **Perinatal Outreach Project**, operated by Children's Hospital Home Health Care Services under contract from the D.C. Commission of Public Health, provides in-home nursing services, social services, and therapeutic services for at-risk prenatal and postpartum women and their newborns. The goal of the project is to improve the health status of low-income pregnant women and infants in the District. At-risk pregnant women and new mothers are referred to the program by local hospitals or the D.C. Department of Human Services. An estimated 80 percent of the 1,000 families served in 1990 were affected in some way by drugs.

The staff of nurses and social workers tracks the mother and child to ensure they are receiving adequate medical care. Staff nurses conduct an average of three to five in-home visits per month. During these visits, they teach the mother about proper prenatal and postpartum care and child-rearing. Staff members also assist families with benefit programs such as Medicaid and WIC and link families with appropriate educational, employment, and substance abuse treatment programs.

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These program descriptions, representing only a sample of the many good programs that exist in our city, are meant to give you a flavor of what you will find as you visit the District's child-serving programs. Other outstanding programs you might want to visit and work with are listed below.

### Child Care and Early Childhood Education

**Calvary Bilingual MultiCultural Learning Center** provides bilingual day care for preschoolers and an after-school program for children ages five to 14 in the Adams Morgan neighborhood.

**Friendship House** offers child care, before- and after-school care, tutoring, and recreational activities for children ages two to 15.

**National Child Day Care Association** operates 15 child care and Head Start centers for preschool children ages three to five, before- and after-school centers for elementary school children, and one family day care home.

**Spanish Educational Development Center** is a bilingual preschool program that serves, in two sites, children ages two to five.

**Washington Child Development Council** is a child care information, referral, and advocacy organization that provides parent education and supports a network of family day care homes.

## Education

**Committee on Public Education (COPE)** provides support to the D.C. Public School system in implementing recommendations that resulted from a study conducted by a broad-based citizen group. COPE also develops private funding and other resources to augment school programs and activities.

**Parents United for D.C. Public Schools** is a citywide education advocacy organization directed by a board of parent representatives from 100 public schools.

**Washington Parent Group Fund** operates programs to support the parents of public school students in their efforts to obtain quality education for their children. Programs include parenting education and a legal assistance project.

## Health

**Children's National Medical Center** is a 279-bed hospital for children and adolescents with a range of community outreach programs, including two primary care clinics, a program for children who have been abused or neglected, and a home-visiting program for high-risk pregnant women.

**Community Health Care, Inc.** provides health care, including maternal and pediatric care, in medically underserved communities. Its clinics are the Upper Cardozo Neighborhood Health Center, Shaw Community Health Center, and East of the River Health Center.

**D.C. General Hospital**, the city's only public hospital, provides prenatal, postpartum, and pediatric health care, including special programs targeted to high-risk mothers and children.

**Greater Southeast Community Hospital** is a 450-bed private hospital with extensive community outreach programs, including a prenatal outreach program and an adolescent health center at Ballou High School.

**Healthy Babies** is a drop-in center that collaborates with a variety of organizations, including the neighborhood health centers and Columbia Hospital for Women, to provide medical and social services for expectant mothers in Ward 5.

**Howard University Hospital** is a university hospital with a full range of inpatient and outpatient prenatal, neonatal, and pediatric services.

**Mary's Center for Maternal and Child Health** provides prenatal, postpartum, and pediatric medical care and other social services to low-income women and children

### Housing and Homelessness

**Churches Conference on Shelter and Housing** is an ecumenical organization that provides technical support and assistance to churches and religious organizations to help them better address the housing needs of the poor.

**Community of Hope** provides transitional housing, health care, and employment services as well as recreation, tutoring, and after-school programs for children.

**ConServe** is a consortium of 10 nonprofit organizations that provides coordinated and integrated support services to homeless families and families at risk of becoming homeless.

**Health Care for the Homeless** provides health and mental health services to homeless individuals and families through health stations located at homeless shelters and a mobile outreach van.

**House of Ruth** operates temporary shelters and transitional housing for homeless women and children.

**Jubilee Housing, Inc.** purchases and renovates housing in the Adams Morgan neighborhood. It works with other components of

Jubilee Ministries to provide health care, employment placement, and other social services.

**MANNA, Inc.** is a nonprofit organization that works in partnership with other organizations to develop and renovate single-family, cooperative, and transitional housing for homeless and low-income families.

**Marshall Heights Community Development Corporation** revitalizes part of the District's Ward 7 through housing development and renovation, commercial development, job training, and social services.

**Mary House** provides transitional housing for homeless mothers and prenatal outreach to high-risk pregnant women.

**MUSCLE, Inc.** is a nonprofit organization that develops low-income housing and transitional housing.

**Washington Legal Clinic for Homelessness** provides case advocacy and political advocacy on behalf of homeless individuals and families.

**YACHAD** provides technical assistance, funding, and a network of volunteer professionals to assist nonprofits and synagogues that want to develop affordable housing.

### Vulnerable Children and Adolescents

**City Lights** is an alternative school for students ages 16 to 21 with special educational and emotional needs.

**Family and Child Services** runs a variety of programs for troubled families and abused and neglected children. It contracts with the Department of Human Services to locate and support foster family homes, including therapeutic foster homes for children with emotional problems, and adoptive families.

**FLOC (For Love of Children)** provides a variety of services for vulnerable children and families, including foster family and group home programs, transitional housing, and a school for students with special needs.

**Grandma's House and Grandpa's House**, operated by TERRIFIC, Inc., provide surrogate care in family-like settings for HIV-positive and other fragile infants with serious medical needs.

**Progressive Life Center** provides culturally relevant mental health treatment for African American children and families. It contracts with the Department of Human Services to provide services for chronic juvenile offenders and therapeutic foster care for children with serious emotional problems.

**Sasha Bruce Youthwork, Inc.** provides programs for runaway youths, teenage mothers, court-referred youths, homeless youths, and other youths in crisis. It also provides temporary shelter, family counseling, individual counseling, and other social support services.

### Youth Development and Recreation

**Barney Neighborhood House** is an after-school recreational and educational program that serves about 30 children, ages six to 12.

**Center For Youth Services** offers comprehensive services to adolescents, including basic skills training, GED preparation, employment training and placement, on-site child care, on-site medical care, and mental health counseling.

**Eastern Branch Boys and Girls Club** provides vocational training, GED preparation, tutoring, recreational activities, and counseling for adolescents ages 12 to 21. It also has programs for homeless youths and teen parents.

**The Latin American Youth Center** provides a drop-in center, recreational programs, cultural activities, vocational training and education programs, and intensive social services for youths ages 12 to 21.

**Living Stage Theatre Company** is the social outreach theater company of Arena Stage. It uses live theater and the arts to promote self-esteem and inspire creativity in children and youths.

**Martha's Table** is an after-school drop-in center for children ages five to 19 that provides meals, tutoring, and recreation activities. It also sponsors a literacy program for mothers and toddlers and a summer day camp.

**Montana Terrace Boys and Girls Club** provides recreation and tutoring programs for children ages five to 19. It conducts regular meetings for parents and involves parents as volunteers.

**National Learning Center** develops and designs innovative educational projects, using computers, video, and the arts as tools for enhancing learning. Programs include the Capital Children's Museum, the Early Learning Center for three- to four-year-olds, and the Options School for troubled seventh-graders.

**Northwest Settlement House** provides developmental day care for children ages three to five, a recreation and tutoring program for elementary school-age children, and a full-day summer camp for children ages six to 13.

**Parklands Community Center** provides tutoring, recreation, and cultural activities, and group and individual counseling for youths ages five to 18.

**Sojourners Neighborhood Center** is an after-school tutoring and recreation program for children ages five to 16. The center provides career workshops and a mentoring program for older youths.

**Sursum Corda Children's Program**, located in the Sursum Corda housing cooperative, provides after-school tutoring and recreational and cultural activities for children ages five to 12.

### How the Community Can Help

Although there are many good programs in the city that help children and families, the need far exceeds the help available. Our goal as a community must be to see many more children and families benefiting from such programs. Every child and family should have access to programs that address their basic health, housing, education, income, emotional, and social needs. Some also will need extra help to address the special needs they may have or to cope with crises that arise.

Every adult must begin by transmitting to all children the message of achievement and possibility and fostering in them a sense of self-worth, hope, and connectedness to the larger community. We must begin by taking an interest in the children and families in our neighborhood. We must also reach out to children in the community at large by volunteering to serve as tutors, mentors, or friends. We should get our churches, synagogues, PTAs, sororities, and civic organizations involved. Major employers in the District have a responsibility to invest dollars and resources directly into the community and encourage and reward employee involvement. Some of us have time, some have money – but we all have skills and resources that allow us to support children in our community.

We must work together to expand the reach of effective programs and services for children and families. But we must do more than that to ensure each child the protection, nurturing, and support needed to survive and thrive. We must work together to eliminate the policy barriers that deprive children of basic support, and to institute laws, policies, and strategies that will improve the circumstances of all the District's children.

### What Individuals and Civic and Social Organizations Can Do

In recent years an increasing number of individuals and civic groups in the District have focused their energies and resources on programs that serve children. Some have started projects of their own to serve the unmet needs of children and others have launched public education campaigns to make children's issues more visible.

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**Concerned Black Men of Washington, D.C.**, is a nonprofit organization of 160 men founded in 1982 to enable the involvement of African American males in the lives of youths. The organization sponsors a variety of programs and activities that are designed to promote the educational, cultural, and social development of area youths. Programs include an Adopt-A-School program at Stanton Elementary School; an outreach project that provides educational and emotional support to incarcerated youths; and Project Northstar, a weekly tutorial program for children living in homeless shelters.

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**The Junior League of Washington** is an organization of 2,700 women committed to improving the community through the effective action and leadership of trained volunteers. For the past three years, "youths at risk" have been among the target areas for fund raising and placement of Junior League volunteers. Thousands of dollars have been raised for local programs and thousands of volunteer hours have been devoted to children. In 1990 the Junior League, with the support of the Eugene and Agnes E. Meyer Foundation, Hallmark Cards Inc., and Nordstrom, produced *Washington's Child*, a publication of striking photographs and bleak statistics that depicts the problems facing the District's children. It is designed to educate and motivate private sector organizations and individuals to become more involved in volunteer projects and to encourage political activism on behalf of children and families.

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**Zeta Phi Beta**, an international black sorority with 130 members in its District Chapter, operates a program out of the Hunt Place Clinic in Southeast in collaboration with the March of Dimes. The program encourages pregnant women to keep their prenatal care appointments. In 1986 the group opened the Stork's Nest, a store that stocks bottles, blankets, diapers, sweaters, and other nursery items. When expectant mothers visit the neighborhood health center for prenatal care, they earn points that entitle them to purchase items in the Stork's Nest. The sorority donates the goods and members volunteer to help in the store and sponsor seminars and discussion groups on health care for the expectant mothers. The program also serves as an informal mentoring program. The volunteers, many of whom have raised their own children, offer advice on nutrition and child-rearing and provide emotional support to the mothers.

### Suggestions for Involvement

- Contact one of the many organizations listed in this chapter, the Volunteer Clearinghouse of D.C., or D.C. Cares to find out about opportunities for volunteering to work with children. You can help take a group of children on a field trip or distribute food on a holiday, or you may want to become involved with a child or a particular agency for a longer time period. Get more involved in your child's school or your civic or social organizations. See what chapters of your organization in other cities are doing.

- If you have talents as a dancer, musician, athlete, writer, actor, or artist, share your expertise when you work as a volunteer with children.

- If you are a member of a professional association, encourage your members to donate their professional skills as physicians, lawyers, or accountants to programs that serve children and families.

- Adopt a local children's program and commit to supporting it with donations of time, supplies, or funds. If there is a children's program in your neighborhood, stop in and see what help it needs.

- Put children at the top of your action agenda. Make a multi-year commitment to improving the lives of children in the District. Educate your friends and colleagues about the problems facing children in the District and what they can do to help. Ensure that your elected officials are putting children first.

*Housing and homelessness*

- Volunteer as a tutor or a "buddy" at one of the city's homeless shelters or with an organization that provides services to low-income children.

- Volunteer to assist nonprofit housing developers such as Manna, Inc., MUSCLE, or ARCH to renovate and rehabilitate low-income housing, to raise money, or to enlist community support for their programs.

- Have your organization work with a community group to offer a homeless family or a family on the brink of homelessness ongoing assistance and support. Help the family with its basic needs, such as housing, food, and employment. Arrange for your children, or children in your membership group, to serve as peer companions for children in the family. Include the family in your recreational and cultural activities.

- If you are a lawyer, volunteer with an organization that provides legal services to families that are facing unlawful eviction, or who are having trouble securing adequate service from their landlords.

*Maternal and child health*

- Help pregnant women and new mothers enroll in the Medicaid program. You can assist by helping women fill out the application forms or by acting as an advocate for an individual woman. Such help is particularly needed for non-English-speaking women.

- Volunteer at a clinic to provide follow-up calls and mail reminder postcards to pregnant women or parents of children who need immunizations, or to provide transportation to the clinic for parents and children.

- Serve as a mentor to a high-risk pregnant woman, providing emotional support, working with her to ensure adequate prenatal care and proper nutrition, and helping her learn about child development and child health, including immunizations.

- If you are a health professional, participate in publicly funded programs and serve a fair share of medically indigent patients. Volunteer with the Commission of Public Health to help keep a clinic open for evening hours. Serve in the community as a resource person to teach family health issues in health clinics, schools, and other community programs.

- Work with a variety of groups including businesses, health professionals, and hospitals, to sponsor health fairs that highlight critical health issues such as immunizations, prenatal care, substance abuse, or AIDS. Include trained professionals who can either administer health remedies (such as vaccinations) or can refer families for appropriate help.

*Vulnerable children and families*

- Become a foster parent by contacting the Child and Family Services Division in the Department of Human Services or one of the organizations listed in Appendix C. Foster parents are especially needed for children with special physical and emotional problems. You might also offer to serve as a respite care resource for foster parents.

- Become a mentor for children and youths in the foster care or juvenile justice system. Mentors can provide tutoring, recreation, cultural enrichment activities, and emotional support. They also can provide useful links for youths when they leave out-of-home care.

- Support the existence in your neighborhood of foster family homes, group homes, and specialized treatment programs for children with serious emotional problems and other special needs.

## What Children and Young Adults Can Do

A big source of service in the community can emerge from young people themselves. College students often have the energy and the flexible hours that allow them to become involved in serving their communities. High school students and even younger children also can become involved. Community service shouldn't be seen as a role only for high achieving youths. Often participation in service activities can help young people cope with the problems they face. By playing meaningful roles in their communities, their sense of self-worth improves and new opportunities may arise.

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**The Howard University Student Association** has been very active in serving the District community through a number of successful outreach programs. Among the many programs sponsored by Howard students, a few are particularly geared toward children and families. At any given time during the academic year anywhere from 50 to 300 students can be found volunteering their time to work in community-based organizations. The students' goals are to provide youths with enhanced self-esteem and educational tools to succeed. Every March Howard students bring together local and national high school and middle school students to a Youth Leadership Retreat where students discuss self-development issues and skills necessary for leadership and attending college. Every April students participate in a massive cleanup or renovation of parks and neighborhoods in the District. In past years the April cleanup has been focused on Malcolm X and Anacostia Parks. Students also participate in monthly clothing drives and collect and distribute materials for low-income families around the city.

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**Georgetown University's Volunteer and Public Service Center** works with about 600 students a semester in a variety of volunteer activities. A number of student groups focus mainly on providing activities for children. The Community Action Coalition provides recreation activities at two sites in the Adams Morgan and Anacostia neighborhoods and conducts a mentoring and tutoring program for children in the Sursum Corda low-income housing development in Northwest. The Coalition for the Advancement of Hispanics provides mentoring and career and college guidance for students at Bell Multicultural High School. A group called GUICE (Georgetown University Integrated Computational Educators) works with teachers in elementary school to assist in the instruction of math, science, and computer use.

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**The Latin American Youth Center**, a drop-in center serving low-income youths, involves its young participants in educating other young people about social issues. The center's Latino Youth Action Project offers opportunities for 30 youths to participate in an array of leadership development activities. In past years participants have conducted educational seminars for other youths on drug abuse prevention and family issues; volunteered at organizations like the Washington Free Clinic and Grandma's House, a home for medically fragile infants; and participated in an AIDS education and prevention program organized by the Center for Population Options. The Youth Center also sponsors a theater group of youth actors and musicians called Latinegro who creatively express issues such as race relations, substance abuse, and teenage pregnancy from a Latino and black perspective to their young audiences. Their productions reach more than 2,000 youths and other community residents a year at schools, health centers, and conferences.

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**Banneker High School** requires its students to complete a total of 270 hours of community service before graduating. Many of the students complete this requirement by volunteering at programs that serve children. In past years, students have completed their requirements by serving as mentors, tutoring younger children, helping to provide recreation activities, making sandwiches for homeless children, and helping nonprofit organizations with administrative work. Counselors at the high school provide suggestions for volunteer projects. The counselors also orient and support the volunteering student and work with the site where the student is placed.

### If You Work with Young People

- If you are a teacher, social worker, or counselor, encourage the young people you work with to become involved in service. Give them the guidance, direction, and supervision they need to respond to the responsibility. Encourage group activities.

- Have your class devote an hour a week to a service activity such as helping renovate a low-income housing unit or staffing a soup kitchen.

- Involve at-risk children in your program as both providers and recipients of service. Adolescents at risk of school failure can be enlisted to help out in classes for younger children; youths who have overcome problems can serve as peer counselors.

- Educate the young people you work with about poverty and homelessness and their impact on children and families. Show them films and videos and encourage them to write research papers or essays. Provide forums for them to discuss how these issues impact their community, and how they can become involved in change.

### If You Are in Elementary School or High School

- Work with younger children in your school, in a nearby children's program, or in a homeless shelter. You may be able to collect clothes or toys for the children, donate food, help younger children with their school work, or help arrange special parties and outings.

- Work with teachers and counselors to create a community service club at your school that helps students become volunteers. Encourage other students and young people to get involved by holding a fair or giving a presentation in an assembly on your group's activities.

- Become a peer counselor for children in your school or at a nearby youth center. Work with an adult counselor to help give presentations on issues such as peer pressure, drugs and alcohol, teen pregnancy, or AIDS. Provide forums for you and your schoolmates to discuss some of these issues.

- You and your classmates can write letters to city council members, the mayor, and the District's delegate to Congress to express your concern for children who are poor or homeless.

## If You Are a College or Graduate Student

- Volunteer to work in a program that serves children through your school, your campus community service program, the Volunteer Clearinghouse of D.C., D.C. Cares, or other groups. Encourage your Greek or ethnic organization to volunteer collectively or to adopt a program. Some possible activities include tutoring, mentoring, or repairing run-down housing units.

- Work with faculty members and the administration to identify programs that your college or university could support through provision of volunteers, money, or technical support. An architecture school could become involved in renovating low-income housing, a medical school in helping to staff a free clinic, and a business school in providing financial advice and accounting services for a nonprofit agency.

- Work with your campus career placement center and your community service center to publicize summer and post-graduation employment opportunities in programs that serve children. Hold a public service job fair and invite nonprofits to give presentations or provide literature on student employment and internship opportunities. Convince your college administration to play an active role in developing public service fellowships that provide stipends for students employed in nonprofits during the summer months.

- Develop a community service program in your school that focuses on the needs of children in the District. Encourage other students and young people to get involved by publicizing the needs of local organizations in your student newspaper or on bulletin boards around your campus. Offer training and ongoing support to volunteers.

- Educate other students about the issues facing children and families by writing articles in your college newspaper or journal, inviting advocates and community leaders to speak, and holding campus-wide forums. Make sure that as you educate people they are given tangible ways to get involved, either by serving as volunteers or becoming politically active.

- Create a campus-based advocacy organization for children. Such an organization would be responsible for educating students and members of the university community on children's issues, informing students about opportunities for political or direct service involvement in children's activities, and serving as the campus liaison to local child advocacy and community groups.

## What Religious Organizations Can Do

Individual churches, synagogues, and auxiliary religious organizations have been at the forefront in speaking out for children. Many have channeled their energies into developing programs that serve not only their members but the needs of the community at large. Some even have formed coalitions and consortiums to be more effective in the community. Most religious organizations have resources to help children: congregants and members who can volunteer, money to help support needy families and local programs, or space to donate to a community group or to start their own programs.

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**The Churches Conference on Shelter and Housing** (CCSH) is an ecumenical organization of churches and nonprofit organizations devoted to creating opportunities for church-sponsored affordable housing. In March 1991 the group began "One Church, One Home," an effort to bring at least 100 new congregations together to address the problems of homelessness in the Washington area. CCSH believes that every congregation has the resources to house at least one homeless family. The group has developed several resource books and provides technical assistance for congregations that want to get involved.

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**The Black Male Youth Enhancement Project** at Shiloh Baptist Church is a program that assists young black men in their transition from boyhood to manhood. The project serves approximately 80 youths between the ages of 11 and 17 and is sponsored jointly by the Shiloh Family Life Center and the D.C. Department of Human Services. The project encourages participants to develop and maintain healthy lifestyles by educating them and developing their self-esteem. The young men give presentations and discuss subjects such as teenage pregnancy prevention, drug abuse, self-esteem, decision making, and job preparation. The youths also use the Family Life Center's cultural, educational, and recreational facilities. Activities include basketball, weightlifting, karate, racquetball, and weekend field trips.

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**The American Jewish Congress**, an organization of 2,000 members, publishes a guide that lists the needs of shelters in the District. The *Guide to Shelter Needs*, which is distributed in cooperation with the Interfaith Conference of Metropolitan Washington to area churches and synagogues, gives the locations and the needs of homeless shelters, soup kitchens, and medical clinics in the area. In addition, the Congress has started to work with YACHAD, a Jewish low-income housing organization, to provide technical assistance and a network of volunteer professionals to congregations that want to develop housing.

• • • •

**The Church Association for Community Services** is a coalition of 80 churches that provides leadership in addressing major social problems in the area. One of its projects is to establish church-based family assistance centers in each of the eight wards of the city. Currently it has established eight centers in Wards 4, 5, 6, 7, and 8. The centers use professional social workers to help families in crisis identify and gain access to the appropriate health, social service, and educational programs to meet their needs. Under the leadership of the Church Association, 15 churches operate after-school programs for children ages six to 14, which provide tutoring and creative activities for youths. Its most recent project, which was officially launched in early 1991, is the Ward 1 Health and Human Services Coalition. The project seeks to coordinate the services of public and private agencies operating in that ward to better serve the needs of multiproblem families.

### Suggestions for Involvement

Every religious organization in the city should be involved in one or more specific projects that reach out to needy children and families in the community. Educate fellow members about the needs of children in the city and how your congregation can become involved. (For more information, order a copy of CDF's *Welcome the Child: A Child Advocacy Guide for Churches*. A version that focuses specifically on African American churches also is being prepared.)

- Ask the worship committee or clergy to hold a worship service that focuses on children and their needs. If you are a clergy member, include children's concerns in your sermon.

- Set up a task force to present data and information on children and to identify programs in which your congregation can become involved. Ask programs in your neighborhood to give you wish lists of their needs, such as volunteers, tutors, supplies, or funds.

- Include information about local programs and children's issues in your newsletter or bulletin. Highlight a major issue such as foster care or homelessness, or highlight a local program that provides volunteer opportunities.

- Work with other groups or community leaders to heighten awareness about at-risk children. Arrange a visit to a local child-serving program for your congregation.

- Encourage members to advocate for children and keep them apprised of what they can do to help children on a local and national level. Work with existing religious networks and children's coalitions to support particular legislation or funding. Use your newsletter or bulletin to inform your congregation of needed action.

Religious congregations also may consider initiating a program or supporting an existing one. The following are presented as suggestions; your congregation may have other ideas it wishes to pursue.

### *Housing and homelessness*

- Work with a community organization to create an emergency fund for homeless families and families at risk of homelessness. Contributions can provide one-time grants or no-interest loans to pay late rent, security deposits, or utility payments. Grants or loans of this type can keep families from losing their homes or help homeless families secure housing.

- Help expand and improve programs for children and families living in homeless shelters. Include homeless children and youths in existing day care, religious education, and other ministries of your congregation. Recruit members of the congregation to provide child care and recreation for homeless children while their parents interview for jobs, attend classes, or seek permanent housing.

- Help develop housing for low-income families. Many congregations in the District area currently are involved in constructing and rehabilitating low-income housing. Work with the One Church, One Home Project of the Churches Conference on Shelter and Housing, the American Jewish Congress, YACHAD, or with nonprofit housing developers.

### *Maternal and child health*

- Work with the Commission of Public Health to adopt a health clinic -- much like the "adopt-a-school" program -- and provide financial support for the clinic, help decorate and repair the clinic, and help with community relations.

- Encourage members of the congregation to volunteer to help with clinic outreach, conduct follow-up calls, and mail appointment reminder postcards to parents of children who need immunizations or pregnant women who need prenatal care.

- Set up and staff a play area in a health clinic or WIC program office for children waiting with family members. Provide education for mothers and pregnant women in the waiting room by presenting printed material regarding immunizations, nutrition, and information about social service resources in the community. Assist with the preparation of an educational video.

- Organize volunteers to transport pregnant women, parents, and children to and from local health clinics that provide prenatal and pediatric care. Work with clinics to advertise the availability of the free transportation and to schedule it at appropriate times.

- Donate congregational space for immunization clinics. Weekend and evening clinics can help working families have access to services. Encourage congregation members to take part in staffing these clinics.

### *Vulnerable children and families*

Help support families and prevent abuse and neglect:

- Sponsor parenting education and parent support groups for members of your congregation and others in your community. Conduct separate sessions for parents of young children, elementary school children, and teenagers. You may want to cosponsor these sessions with local schools or neighborhood health centers.

- Establish a family resource and support center in your community that provides family support services. Such centers can help strengthen families and prevent crises.

- "Adopt" a social worker in the Child and Family Services Division of the Department of Human Services. Help support that worker by responding to the unmet needs of the children and families he or she is serving. The worker may ask for basic supplies, such as food, clothing, or health care supplies; for financial assistance to get the family through a crisis; or for help with transportation, child care, or other services.

Assist children in or returning from out-of-home care:

- Encourage members of your congregation to consider becoming foster parents. Give foster parents who are in your church the opportunity to share their experiences with others. Set up a network of families that are available to offer assistance to the foster families when emergencies arise.

- Many of the young people "aging out" of foster care at 18 or 19 years old have no family or friends to whom they can return. Volunteers from young adult groups may be willing to serve as community sponsors for these young people.

- Develop programs for youths who are returning from various juvenile detention facilities. Such programs may provide mentoring and material, emotional, and educational supports for youths and their families.

Help find adoptive families for children:

- Work with local organizations, other religious organizations, and public agencies to begin a "One Church, One Child" campaign that helps recruit families to adopt children who are waiting for families. The One Church, One Child program began in Illinois and now is in 23 states. Each church identifies a family to adopt a child and then functions as a support system for the family.

- Encourage members of your congregation to consider adopting children with special needs, particularly children who have various mental, emotional, or physical disabilities, or who are older or part of a sibling group.

- Sponsor a post-adoption support group for families that have adopted children with special needs. Sponsorship could involve making space available for monthly meetings, offering clerical support for the group's regular communications, or offering child care assistance for parents who are attending the meetings.

### What Businesses Can Do

All businesses, from big corporations and law firms to smaller neighborhood businesses, can contribute to the community through corporate giving programs, assistance with fund raising, supplying volunteers or materials, and free technical expertise to nonprofit organizations.

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The ARCH (Action to Rehabilitate Community Housing) program was started by the Potomac Electric Power Company (PEPCO) in 1986 to help revitalize neighborhoods east of the Anacostia River. ARCH offers unemployed adults and teenagers job skills training and job placement; renovates substandard housing for homeless and low-income families; constructs affordable housing; provides transitional housing, social services, and case management services for homeless families; and provides technical assistance to small contractors that develop housing in these neighborhoods.

• • • •

Fannie Mae (the Federal National Mortgage Association) not only raises funds for programs such as Martha's Table and Community of Hope that help children and families, but involves its staff in volunteer and fund raising efforts. More than 100 staff members serve as volunteer mentors in Fannie Mae's Adopt-A-School Program with H.D. Woodson High School in Northeast. Employees are allowed to take up to 10 hours a month from their regular work time to participate in the Woodson program. Employees also participate in Fannie Mae's annual Help the Homeless Week by contributing money and by participating in a walkathon to help raise money for organizations that provide services to the homeless. A steering committee of employees works with local volunteer placement organizations to keep staff regularly informed of ongoing as well as one-time volunteer opportunities.

• • • •

Repete Couriers is a small courier business located in the Shaw neighborhood that services the downtown area. The owner, Ernest Peterson, uses the resources of his small business to aid the community. Repete Couriers employs 16 young men, most of whom come from low-income families in Shaw, as couriers and as office workers. Many of these youths are high school dropouts who are at risk of becoming involved in the drug trade, and who, without Peterson and Repete Couriers, would have difficulty finding their first jobs. Peterson serves as a mentor and role model to the young men while his business helps them gain employment experience. Repete Couriers also operates a scholarship program with a local elementary school. Twenty students are given savings bonds that later can be used to pay for their college expenses. The program started in 1982 and so far three students have used the $1,000 savings bonds to help pay for college.

### Suggestions for Involvement

Encourage family-centered policies in your business or place of employment:

- Employers can help single parents and parents of young children by providing child care assistance, paid parental leave, and flexible or part-time work schedules, including work-at-home options, that accommodate family responsibilities.
- Whenever possible, establish new child care facilities on-site or at nearby locations. These programs should receive enough financial assistance to make them affordable for all employees. If you are a small employer, work in consortium with other employers to provide child care for employees.
- Implement policies and programs responsive to employees' family needs. Programs might include parenting education class-

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es, in-house counseling, and resource and referral services for child care, alcohol and drug treatment, and mental health services.

- Offer subsidized health insurance with dependent coverage to all employees regardless of pay level. Plans should cover cost-effective services such as prenatal care and preventive care fully for children.

- Institute corporate wellness policies that support families. Employees should have adequate sick and family leave. In addition, employers should offer opportunities for employees to reduce stress, fight substance abuse, and gain health education through the work place.

Educate your staff and encourage employees to become more involved in children's issues:

- Encourage your staff to become involved in volunteer efforts in the community. Do this by listing volunteer opportunities on a bulletin board or in a newsletter and providing leave or flex time for those involved in volunteer efforts during work hours. Hold a volunteer fair and invite local volunteer placement organizations to give presentations. Recognize employees who volunteer.

- Encourage your community relations department to work closely with community-based organizations and child advocacy groups to keep informed of the needs of the community. Invite community speakers to discuss how staff members can become more involved in specific efforts and campaigns.

Support or develop programs that help children and families:

- Contribute money, materials, and expertise (through consultation or staff loans) to nonprofit organizations. For example:
    - Donate space, equipment, and supplies to a local nonprofit. Ask nonprofits for wish lists of their needs.
    - Lend a member of your staff who has expertise in accounting, law, public relations, or fund raising. Encourage staff members to offer their expertise through time-sharing arrangements.

  - If you have extra spaces in computer training, management training, or leadership development courses, make them available to nonprofit organizations.

  - Serve on the boards and committees of nonprofit organizations.

  - Create a program that donates money to a nonprofit organization in the name of an employee who has done a good job.

  - Underwrite advertising space or help produce pamphlets and brochures for organizations seeking foster parents and adoptive parents.

- Sponsor a job fair and target slots in your training and employment programs for parents in low-income families. Work with organizations that help these families and offer financial support, professional expertise, staff loans, volunteers, services, and other assistance as needed.

- Allocate funds to help pay the costs of child care for low-income employees and establish scholarship funds through resource and referral programs for other low-income families in the community.

- Work with the Department of Employment Services, community-based organizations, and schools to create summer and after-school employment opportunities and job training programs for disadvantaged youths.

- Create partnerships with schools and community-based organizations. These partnerships can build mentoring and tutoring programs, employment-related activities, and social activities that bring students and adults into regular and sustained contact. Staff members should be encouraged to become personally involved with the youths in the programs.

- If you develop commercial and luxury real estate consider how you may help construct low-income housing.

- Collaborate with community-based service organizations, religious organizations, and other businesses to adopt a neighborhood for special attention. Help create family resource and support centers, affordable housing, start-up help or business incubators for small businesses, and other community development programs.

## What We All Must Do To Place Children Higher on the Political Agenda

> *You know, people tells you, don't talk politics, but the air you breathe is polluted air, it's political polluted air. The air you breathe is politics. So you have to be involved. You have to be involved in trying to elect people that's going to help do something about the liberations of all people.*
>
> Fannie Lou Hamer, Mississippi civil rights organizer, "It's in Your Hands"
> May 7, 1971

As we work to support individual children and families and to strengthen and expand individual programs on their behalf, we must not lose sight of the need for action in the policy and political arenas as well. As citizens, community leaders, religious leaders, students, and business people we must speak out for fair public policies for children and families. We must share our knowledge of the harms children face. We must also let our political leaders know what works and that investments in these good programs cost less than teen pregnancy, special education, welfare dependence, and incarceration. We must let them know what changes are needed in laws, policies, and programs to improve the lives of children. We must make sure that no law is enacted and no budget is passed without thought being given first to its impact on children. As a city, we must put children first.

Begin by staying informed about the legislative process:

- Call the appropriate City Council committees and the office of the congressional delegate to find out about legislative action relevant for children and families. Order a legislative calendar to keep informed of City Council hearings, meetings, and legislation.

- Circulate in your group's bulletin or newsletter information on important legislation. Instruct your members on how to act on it.

- Maintain regular contact with advocacy groups and service providers to keep informed of the relevant issues and action needed.

Communicate the needs of children to the mayor and your council member, to council committees, to your school board member, and to your congressional delegate:

- Write a letter anytime but particularly when a vote is expected on an issue. Encourage others to write to their elected officials.
- Testify at budget hearings, usually held in early spring each year. Talk about the need to invest in health care, child care, income supports, and special services for children. Encourage groups that are not traditionally involved in giving testimony, such as business groups, to testify. Attend public round-tables and oversight hearings on children's programs.
- Meet with your elected officials or the staff of key children's committees to discuss in greater depth the needs of children in your ward or neighborhood. Try to give some practical solutions to the problems facing children along with expressing your willingness to help. Invite officials and their staffs to visit programs and suggest ways such programs can be expanded.
- Because of the District's status as a federal jurisdiction, be sure to include in your communications members of Congress, particularly those on the D.C. appropriations committees, as well as the President of the United States.

Make children's issues key issues in your next ward election:

- Deliver a message on the importance of investing in children and provide candidates with a fact sheet on children's needs.
- Organize a committee to sponsor a ward meeting to discuss the most pressing problems of children in your ward. Discuss solutions to address the problems and distribute materials on children's needs to all the participants.
- Sponsor a candidates' forum to hear their positions on key issues affecting children; question the candidates about what they would do to help children with their health, housing, education, income, and other critical needs.
- Work on a Get Out The Vote campaign to register students and community members for the next election. Distribute fact sheets to educate voters about child and family issues.

## Appendix A

# Who's In Charge?

### ELECTED OFFICIALS

**Sharon Pratt Dixon**
Mayor of the District of Columbia
The District Building
1350 Pennsylvania Avenue, N.W.
Washington, DC 20004
727-3000

**Eleanor Holmes Norton**
Congressional Delegate
1631 Longworth House Office Building
Washington, DC 20515
225-8050

**City Council**
The District Building
1350 Pennsylvania Avenue, N.W.
Washington, DC 20004
727-8000

**John Wilson**, Council Chairman, At-Large
Room 107 724-8178
Executive Assistant: Eric Jones

**Linda Cropp**, Councilmember At-Large
Room 108 724-8032
Executive Assistant: Ted Trabue, Jr.

**William Lightfoot**, Councilmember At-Large
Room 119 724-8045
Executive Assistant: Thomas Blanton

**Hilda H.M. Mason**, Councilmember At-Large
Room 118 724-8064
Executive Assistant: Janet Keenan

**John Ray**, Councilmember At-Large
Room 102 724-8105
Executive Assistant: Estelle Lloyd

**Frank Smith, Jr.**, Councilmember, Ward 1
Room 122 724-8072
Executive Assistant: Mark Brown

**Jack Evans**, Councilmember, Ward 2
Room 101 724-8058
Executive Assistant: Linda Greenan

**James E. Nathanson**, Councilmember, Ward 3
Room 111 724-8181
Executive Assistant: Susan Vener

**Charlene Drew Jarvis**, Councilmember, Ward 4
Room 121 724-8052
Executive Assistant: Dawn Alexander

**Harry Thomas, Sr.**, Councilmember, Ward 5
Room 106 724-8028
Executive Assistant: Diane Romo

**Harold Brazil**, Councilmember, Ward 6
Room 110 724-8174
Executive Assistant: Robert Robinson

**H.R. Crawford**, Councilmember, Ward 7
Room 116 724-8068
Executive Assistant: Alita Collier

**Wilhelmina Rolark**, Councilmember, Ward 8
Room 125 724-8062
Executive Assistant: Clydie Smith

To order copies of legislation and the council's weekly calender, contact **Legislative Services** at 724-8050.

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## *Key Committees for Children*

**Committee of the Whole**
John Wilson, Chairperson
All Councilmembers
Committee Clerk: Toni Perry, 724-8121
Relevant areas of oversight: Finance and Revenue.

**Committee on Human Services**
H.R. Crawford, Chairperson
Charlene Drew Jarvis, John Ray, Wilhelmina Rolark, Harry Thomas
Committee Clerk: Ron Collins, 724-8196
Relevant areas of oversight: Department of Human Services.

**Committee on Education and Libraries**
Hilda H.M. Mason, Chairperson
Harold Brazil, William Lightfoot, James Nathanson, Harry Thomas
Committee Clerk: James Ford, 724-8119
Relevant areas of oversight: District of Columbia Public Schools.

**Committee on Housing**
Frank Smith, Chairperson
Linda Cropp, Charlene Drew Jarvis, John Ray, Wilhelmina Rolark
Committee Clerk: Robert Goldman, 724-8029
Relevant areas of oversight: Department of Housing and Community Development; Housing Finance Agency; Department of Public and Assisted Housing.

**Committee on Public Services**
William Lightfoot, Chairperson
Linda Cropp, James E. Nathanson, Frank Smith, Jr., Jack Evans
Committee Clerk: Eric McFarland, 724-8045
Relevant areas of oversight: Department of Recreation; Office of Latino Affairs; Commission on Latino Community Development.

**District of Columbia Board of Education**
415 12th Street, N.W.
Washington, DC 20004

**R. David Hall**, President
Ward 2
724-5459

**Nate Bush**, Vice President
Ward 7
724-5447

**Dr. Franklin Smith**
Superintendent of Schools
724-4222

**The Reverend David H. Eaton**
At-Large
724-5456

**Wilma Harvey**
Ward 1
724-5461

**Angie Corley**
Ward 5
724-5451

**Karen Shook**
At-Large
724-5450

**Erika Landberg**
Ward 3
724-5457

**Iris Toyer**
Ward 6
724-5449

**Jay Silberman**
At-Large
724-5452

**Sandra-Butler Truesdale**
Ward 4
724-5453

**Linda Moody**
Ward 8
724-5460

## OTHER KEY DISTRICT GOVERNMENT OFFICIALS

### Department of Human Services

**Vince Gray**
Director
801 North Capitol Street, N.E., Suite 700
Washington, DC 20002
727-0310

**Pat Watt**
Deputy Director for Program Operations
801 North Capitol Street, N.E.
Suite 700
Washington, DC 20002
727-0310

**Barbara Kamara**
Director, Office of Early Childhood Development
609 H Street, N.E.
Washington, DC 20002
727-1839

**J. Lee Partridge**
Chief, Office of Health Care Financing
2100 M.L. King Jr. Avenue, S.E.
Suite 302
Washington, DC 20020
727-0735

### *Commission of Public Health*

**Georges Benjamin, M.D.**
Commissioner of Public Health
1660 L Street, N.W.
Washington, DC 20036
673-7700

**Caitlin Ryan**
Chief, Office of AIDS Activities
1660 L Street, N.W.
Washington, DC 20036
673-3679

**Marlene Kelley, M.D.**
Administrator, Ambulatory Health Care Administration
1660 L Street, N.W.
Washington, DC 20036
673-6670

(Vacant)
Deputy Commissioner of Public Health
1660 L Street, N.W.
Washington, DC 20036
673-7700

**Martin Levy, M.D., M.P.H.**
Administrator, Preventive Health Services Administration
1660 L Street, N.W.
Washington, DC 20036
673-6741

**John A. Jackson, Jr.**
Administrator, Alcohol and Drug Abuse Services Administration
1300 First Street, N.E.
Room 319
Washington, DC 20036
727-0740

**Pat Thompkins**
Director, Office of Maternal and Child Health
1660 L Street, N.W.
Washington, DC 20036
673-6800

## *Commission on Social Services*

**Kathryn Williams**
Acting Commissioner on Social Services
609 H Street, N.E., Fifth Floor
Washington, DC 20002
727-5930

**Elizabeth Parker**
Acting Administrator, Family Services Administration
Randall Building
1st and Eye Streets, S.W.
Washington, DC 20024
727-5947

**Charles Howard**
Acting Administrator, Youth Services Administration
717 14th Street, N.W.
Sirth Floor
Washington, DC 20005
727-9310

**Ernest Taylor**
Chief, Office of Emergency Shelter and Support Services
25 M Street, S.W.
Washington, DC 20024
727-2030

**Diane Stokes**
Acting Chief, Office of Paternity and Child Support Enforcement
425 I Street, N.W.
Third Floor
Washington, DC 20001
724-5610

**James Butts**
Administrator, Income Maintenance Administration
645 H Street, N.E.
Washington, DC 20002
724-5506

## *Commission of Mental Health Services*

**Robert Washington**
Commissioner of Mental Health Services
2700 Martin Luther King Jr. Avenue, S.E.
Washington, DC 20032
373-7166

**Pat McCarthy**
Acting Administrator, Children and Youth Services Administration
1120 19th Street, N.W.
Washington, DC 20036
673-7784

## Department of Housing and Community Development

**John F. Hampton**
Acting Director
51 N Street, N.E.
Washington, DC 20002
535-1970

## Department of Public and Assisted Housing

**Ray Price**
Acting Director
1133 North Capitol Street, N.E.
Washington, DC 20002
535-1510

## Office of Latino Affairs

**Rita Soler-Ossolinski**
Acting Director
2000 14th Street, N.W., 2nd Floor
Washington, DC 20009
939-8765

## FEDERAL GOVERNMENT

### U.S. Senate: Committee on Appropriations, Subcommittee on District of Columbia

**Sen. Brock Adams** (D-WA)
Chairperson
224-2621

**Timothy Leeth**
Committee Staff Director
Capitol Building, Room S-20
Washington, DC 20510-6029
224-2731

**Sen. Christopher (Kit) Bond** (R-MO)
Ranking Minority Member
224-5721

**Sen. Wyche Fowler, Jr.** (D-GA)
224-3643

**Sen. Slade Gorton** (R-WA)
224-3441

**Sen. Bob Kerrey** (D-NE)
224-6551

### U.S. House of Representatives: Committee on District of Columbia

**Rep. Ronald V. Dellums** (D-CA)
Chairman
225-2661

**Edward Sylvester, Jr.**
Majority Staff Director
1310 Longworth House Office Building
Washington, DC 20515-6070
225-4457

**Rep. Thomas J. Bliley, Jr.** (R-VA)
Ranking Minority Member
225-2815

**Rep. Larry Combest** (R-TX)
225-4005

**Rep. Mervyn Dymally** (D-CA)
225-5425

**Rep. William Gray, III** (D-PA)
225-4001

**Rep. Jim McDermott** (D-WA)
225-3106

**Rep. Eleanor Holmes Norton** (D-DC)
225-8050

**Rep. Dana Rohrabacher** (R-CA)
225-2415

**Rep. Fortney (Pete) Stark** (D-CA)
225-5065

**Rep. Alan Wheat** (D-MO)
225-4535

### U.S. House of Representatives: Committee on Appropriations, Subcommittee on District of Columbia

**Rep. Julian C. Dixon** (D-CA)
Chair
225-7084

**Americo S. Miconi**
Staff Assistant
Capitol Building, Room H-301
Washington, DC 20515-6019
225-5338

**Rep. Dean Gallo** (R-NJ)
Ranking Minority Member
225-5034

**Rep. Les AuCoin** (D-OR)
225-0855

**Rep. Tom DeLay** (R-TX)
225-5951

**Rep. Steny Hoyer** (D-MD)
225-4131

**Rep. William Natcher** (D-KY)
225-3501

**Rep. Ralph Regula** (R-OH)
225-3876

**Rep. Martin Sabo** (D-MN)
225-4755

**Rep. Louis Stokes** (D-OH)
225-7032

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## Appendix B

# Volunteer Opportunities

**The Volunteer Clearinghouse of D.C.**
1313 New York Avenue, N.W.
Washington, DC 20005
638-2664

A comprehensive listing of volunteer opportunities in the District, including a volunteer directory and a community wish list.

***Washington, D.C. Volunteer Guide***

A comprehensive directory of volunteer opportunities in the District. To order, send $1.00 for postage and handling to the Volunteer Clearinghouse of D.C.

**D.C. Cares**
2300 N Street, N.W., Fifth Floor
Washington, DC 20037
663-9207

Provides a range of volunteer projects specifically geared to working people.

**Community and Volunteer Service Unit**
D.C. Public Schools
415 12th Street, N.W.
Washington, DC 20004
727-4000

Works with parents and community to coordinate citizen involvement in schools.

***The Helping Hand Book: Volunteer Opportunities to Reduce Long-Term Poverty in the District of Columbia***

A guide to volunteer opportunities in education and mentoring programs in the District. To order, contact:

The Greater Washington Research Center
1717 Massachusetts Avenue, N.W., Suite 403
Washington, DC 20036-2076
387-0900

**Mentors, Inc.**
K Street, N.W., Suite 406
Washington, DC 20001
393-0512

Matches mentors with students in the D.C. public schools.

## Appendix C

# Helping Hands for the District's Children

**American Jewish Congress**
National Capital Region
2027 Massachusetts Avenue, N.W.
Washington, DC 20036
332-4001
Jane Merkin, Director

**Anacostia/Congress Heights Partnership for the Prevention of Homelessness**
2307 Martin Luther King, Jr. Avenue, S.E.
Washington, DC 20020
889-2102
Brenda Richardson, Executive Director

**ARCH (Action to Rehabilitate Community Housing)**
2427 Martin Luther King, Jr. Avenue, S.E.
Washington, DC 20020
889-2447
Duane Gautier, President

**Banneker Senior High School**
800 Euclid Street, N.W.
Washington, DC 20001
673-7322
Vernita Jefferson, Director of Community Service Program

**Barney Neighborhood House**
3118 16th Street, N.W.
Washington, DC 20010
939-9000
(Vacant), Director, Youth Program

**Black Male Youth Enhancement Project**
Family Life Center
Shiloh Baptist Church
1510 Ninth Street, N.W.
Washington, DC 20001
232-4200
Gerard Bingham, Acting Director

**Calvary Bilingual Multicultural Learning Center**
1459 Columbia Road, N.W.
Washington, DC 20009
332-8697
Beatriz Otero, Director

**Center For Youth Services**
921 Pennsylvania Avenue, S.E.
Washington, DC 20003
543-5707
Sam Tramel, Executive Director

**Children's National Medical Center**
111 Michigan Avenue, N.W.
Washington, DC 20010
939-4930
Jacqueline Bowen, Director, Government and Community Affairs

**Church Association for Community Service**
710 Randolph Street, N.W.
Washington, DC 20011
541-5012
Rev. Frank Tucker, Chairman

**Churches Conference on Shelter and Housing**
1711 14th Street, N.W.
Washington, DC 20009
232-6748
Rev. Keary C. Kincannon, Executive Director

**City Lights**
724 9th Street, N.W.
Washington, DC 20001
347-5010
Bert L'Homme, Executive Director

**Committee on Public Education (COPE)**
1155 15th Street, N.W., Suite 500
Washington, DC 20005
835-9011
Conrad Snowden, Executive Director

**Community Health Care, Inc.**
P.O. Box 62240
Washington, DC 20029-2240
745-4441
James Speight, Executive Director

**Community of Hope**
1417 Belmont Street, N.W.
Washington, DC 20009
232-9091
Tom Nees, Executive Director

**Community Partnership for the Prevention of Homelessness**
1700 Pennsylvania Avenue, N.W., Suite 800
Washington, DC 20006
624-1731
Sue Marshall, Executive Director

**Concerned Black Men of Washington, D.C.**
655 15th Street, N.W., Suite 300
Washington, DC 20005
639-4052
Eugene Boyd, Secretary

**ConServe**
707 8th Street, S.E.
Washington, DC 20003
547-7388
Tony Russo, Executive Director

**D.C. General Hospital**
19th and Massachusetts Avenues, S.E.
Washington, DC 20003
675-2003
Ann Chisholm, Director of Media Relations

**Eastern Branch Boys and Girls Club**
261 17th Street, S.E.
Washington, DC 20003
543-3887
Rudy Stokes, Branch Executive

**Edward C. Mazique Parent Child Center**
1325 W Street, N.W.
Washington, DC 20009
462-3375
Ruth Rucker, Executive Director

**Family and Child Services**
929 L Street, N.W.
Washington, DC 20001
289-1510
Rhoda Veney, Director

**The Family Place**
3309 16th Street, N.W.
Washington, DC 20010
265-0149
Maria Elena Orrego, Program Director

**Federal National Mortgage Association (Fannie Mae)**
3900 Wisconsin Avenue, N.W.
Washington, DC 20016
752-7000
Harriet Ivey, Vice President for Community Relations

**FLOC (For Love of Children)**
1711 14th Street, N.W.
Washington, DC 20009
462-8686
Fred Taylor, Executive Director

**Friendship House**
619 D Street, S.E.
Washington, DC 20003
675-9050
Teresa Buck, Director, Youth Program

**Georgetown University Volunteer and Public Service Center**
P.O. Box 2255
Georgetown University
Washington, DC 20057
687-3703
Mina Veazie, Director

**Grandma's House**
c/o TERRIFIC, Inc.
1222 T Street, N.W.
Washington, DC 20009
234-4128
Joan McCarley, Program Administrator

**Greater Southeast Community Hospital**
1310 Southern Avenue, S.E.
Washington, DC 20032
574-6646
Michelle LeSane, Director of Community Relations

**Health Care for the Homeless**
1511 K Street, N.W., Suite 500
Washington, D.C. 20005
628-5660
Vincent A. Keane, Executive Director

**Healthy Babies**
1507 Benning Road, N.E., Lower Level
Washington, DC 20002
396-2809
Delores Parr, Director

**High Intensity Supervision (HITS) Program**
409 E Street, N.W., Room 302
Washington, DC 20001
508-1627
Carroll Boswell, Program Director

**House of Ruth**
501 H Street, N.E.
Washington, DC 20002
547-6173
Ellen Rox, Executive Director

**Howard University Hospital**
2041 Georgia Avenue, N.W.
Washington, DC 20060
865-1471
Sharon Robinson, Director of Marketing and Development

**Jubilee Housing, Inc.**
1750 Columbia Road, N.W.
Washington, DC 20009
332-4020
Bob Boulter, Vice President

**Junior League of Washington, D.C.**
3039 M Street, N.W.
Washington, DC 20007
337-2001
Margie Deane Gray, President

**The Latin American Youth Center**
3045 15th Street, N.W.
Washington, DC 20009
483-1140
Lori Kaplan, Executive Director

**Living Stage Theatre Company**
1901 14th Street, N.W.
Washington, DC 20009
234-5782
Robert Alexander, Director

**MANNA, Inc.**
P.O. Box 26049
Washington, DC 20001
232-2844
Jim Dickerson, Executive Codirector

**Marshall Heights Community Development Corporation**
3917 Minnesota Avenue, N.E.
Washington, DC 20019
396-1200
Lloyd Smith, Executive Director

**Martha's Table**
2114 14th Street, N.W.
Washington, DC 20009
328-6608
Pam Selden, Director of Children's Programs

**Mary House**
4303 13th Street, N.E.
Washington, DC 20017
635-0534
Sharon Murphy, Director

**Mary's Center for Maternal and Child Health**
1844 Columbia Road, N.W.
Washington, DC 20009
483-8196
Mary Gomez, Executive Director

**Montana Terrace Boys and Girls Club**
1733 Montana Terrace, N.E.
Washington, DC 20018
529-7222
Leonard Lee, Director

**MUSCLE, Inc.**
900 2nd Street, N.E., Suite 110
Washington, DC 20002
371-0471
Alice Vetter, Executive Director

**National Child Day Care Association**
1501 Benning Road, N.E.
Washington, DC 20002
397-3800
Helen Taylor, Executive Director

**National Learning Center**
800 3rd Street, N.E.
Washington, DC 20002
543-8600
Ann Lewin, President

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**Northwest Settlement House**
448 Ridge Street, N.W.
Washington, DC 20001
638-4736
Ronald R. Wilmore, Executive Director

**Parents United for D.C. Public Schools**
1400 I Street, N.W., Suite 450
Washington, DC 20005
289-4988
Delabian Rice-Thurston, Director

**Parklands Community Center**
3320 Stanton Road, S.E.
Washington, DC 20020
678-6500
Brenda Jones, Executive Director

**Perinatal Outreach Project**
Children's Hospital Home Health Care Services
111 Michigan Avenue, N.W.
Washington, DC 20010
939-4663
Connie Logan-Hazel, Director
Jennifer Kennedy, Clinical Manager

**Progressive Life Center**
1123 11th Street, N.W.
Washington, DC 20001
842-4570
Dr. Fred Phillips, Executive Director

**Repete Couriers**
1412 Fifth Street, N.W.
Washington, DC 20001
462-3743
Ernest Peterson, President

**Sasha Bruce Youthwork, Inc.**
1022 Maryland Avenue, N.E.
Washington, DC 20002
675-9340
Deborah Shore, Executive Director

**Sojourners Neighborhood Center**
1323 Girard Street, N.W.
Washington, DC 20009
387-7000
Barbara Tamialis, Director

**Spanish Educational Development Center**
1840 Kalorama Road, N.W.
Washington, DC 20009
462-8848
Martha Egas, Director

**Sursum Corda Children's Program**
1160 1st Place, N.W.
Washington, DC 20001
289-8733
Alverta Munlyn, Director

**Washington Child Development Council**
2121 Decatur Place, N.W.
Washington, DC 20008
387-0002
Bobbi Blok, Executive Director

**Washington Legal Clinic for Homelessness**
1800 Massachusetts Avenue, N.W., Sixth Floor
Washington, DC 20036
872-1494
Leslie Plant, Administrator

**Washington Parent Group Fund**
1400 I Street, N.W., Suite 715
Washington, DC 20005
789-0070
Joy Majied, Director

**YACHAD**
4834 Rodman Street, N.W.
Washington, DC 20016
363-4501
Ed Rehfeld, Coordinator

**Zeta Phi Beta of D.C.**
c/o National Headquarters
1734 New Hampshire Avenue, N.W.
Washington, DC 20009
387-3103
Julia Smith, President

## Appendix D

# Selected Resources

**Children and Family Services in the District of Columbia.** Testimony prepared for LaShawn A. v. Barry, The Center for the Study of Social Policy, Washington, D.C., September 1990

**Children in the District of Columbia: Census Update 1986.** Prepared by the Office of the Special Assistant for Human Resource Development, The District of Columbia Government, Washington, D.C., September 1988

**Commercial Office Buildings in Washington, D.C.: Underassessed.** Service Employees International Union, Washington, D.C., May 1989

**Crime and Justice Report for the District of Columbia.** Office of Criminal Justice Plans and Analysis, The District of Columbia Government, Washington, D.C., June 1991

**Doubled-Up Households in the District of Columbia.** Prepared by the Office of the Special Assistant for Human Resource Development, Office of the Mayor, The District of Columbia Government, Washington, D.C., February 1989

**The District's War on Drugs: Final Report to the Mayor.** Prepared by the Office of Drug Control Policy, The District of Columbia Government, Washington, D.C., December 1990

**Final Mental Health System Implementation Plan: Reorganization Plan No. 3 of 1986 and Attachments.** Mental Health System Reorganization Office, Department of Human Services, The District of Columbia Government, Washington, D.C., 1986

**Financing the Nation's Capital.** The Report of the Commission on Budget and Financial Priorities of the District of Columbia, Washington, D.C., November 1990

**Fiscal Year 1989 Annual Report on the Implementation of the Prevention of Child Abuse and Neglect Act of 1977.** Prepared by the Child and Family Services Administration, Department of Human Services, The District of Columbia Government, Washington, D.C., Fall 1990

**Indices: A Statistical Index to District of Columbia Services.** Office of Policy and Program Evaluation, The District of Columbia Government, Washington, D.C., August 1991

**Opportunity Ladders: Can Area Employment Possibilities Improve the Prospects for Washingtonians in Long-Term Poverty?** The Committee on Strategies to Reduce Chronic Poverty, Greater Washington Research Center, Washington, D.C., 1988

**Rental Housing Crisis Index.** Low Income Housing Information Service, (LIHIS), Washington, D.C., March 1986

**Residents Without Health Insurance: Who's At Risk?** Office of the Special Assistant for Human Resource Development, The District of Columbia Government, Washington, D.C., February 1989

**Stuck at the Shelter: Homeless Children and the D.C. School System.** National Law Center on Homelessness and Poverty, Washington, D.C., September 1990

**Who's Poor in the District of Columbia?** Prepared by the Office of the Special Assistant for Human Resource Development, The District of Columbia Government, Washington, D.C., September 1988

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